PAYER ID: SUBMITTER ID:

Emdeon ERA Provider Information Form

*This form is to ensure accuracy in updating the appropriate account

1 Provider Organization

Practice/ Facility Name		Provider Name			
Tax ID		Client ID		Site ID	
Address		City/State		Zip Code	
Contact Name					
E-mail Address		Telephone		Fax	

2 Vendor *(Emdeon certified vendor used to submit files to Emdeon)*

Vendor Name		Vendor Submitter ID		Division ID	
Contact Name					
E-mail Address					

3 Payer

Payer ID		
Group ID	Individual Provider ID	NPI ID

4 Confirmations

Send Emdeon Claim Confirmations To:	

Special Instructions:

- **All Payer Registration forms must contain signatures when applicable, stamped signatures or photocopies are accepted.**
- **SUBMIT COMPLETED FORM TO:**
  Fax: (615) 231-4843
  Email: batchenrollment@Emdeon.com

ENROLLMENT MUST BE PROCESSED THROUGH EMDEON

PLEASE DO NOT SUBMIT FORM DIRECT TO PAYER

EMDEON REVISION FORM DATE:

CIGNA HealthCare

Electronic Remittance Advice (ERA) Provider Registration Request and Cancel Form

Instructions to Clearinghouse:

A. **Please complete this form for a Provider requesting to register to receive an Electronic Remittance Advice (ERA) from CIGNA HealthCare, or, requesting to cancel an ERA registration (including a cancellation due to provider change in Clearinghouse).**

B. **E-mail to: Cignaera@cigna.com, up to daily, as needed, to CIGNA HealthCare.**

Notes:

a) Provider Records will be updated within 10 business days of receipt of this form by CIGNA HealthCare.

b) ERA's will be produced beginning the first payment cycle after the ERA effective date:
- for claims received after the ERA effective date,
- for claims received before the ERA effective date, if processed and consolidated on the same check with claims received after the ERA effective date.

Note that the "ERA effective date" is the date requested, or, the current date at the time the registration request is processed by CIGNA, whichever is later. Retroactive dates are not accommodated.

c) ERA election will be effective for all practitioners registered within the same TIN#.

d) IF you elect to have ERAs for the same TIN distributed by Service Facility you will need to submit the Service Facility ID number on your claims. Please check with your clearinghouse for more detail.

e) Explanation of Payments (currently provided) will continue to be produced.

(1) Action Requested

Select One:	☒ Enroll for ERA (Note: Explanation of Payments currently provided will continue)	❑ Cancel ERA (Note: For any reason, including change in Clearinghouse)

(2) Effective Date:

Indicate the ERA Effective Date or Cancel Date requested. *(specify date – mm/dd/yyyy) (Note: Future date only)*

(3) Provider Information (Please select those that apply)

❑ Medical ❑ Dental ❑ Both

❑ Distribute ERA by Service Facility

Please complete all of the following:	
• TIN # (to which payment will be made)	
• TIN # Type (indicate SS# or EIN)	
• TIN Name as it appears on W9	

Please complete applicable options below:	
• Solo Practitioner First/Last Name & Degree	
• Group Name (if applicable)	
• Facility Name	
• Ancillary Name	

Billing Address:	
• Street / PO Box	
• City	
• State	
• Zip	

Please X applicable options:			
For Facilities:		*For Ancillary:*	
Hospital		DME	
Hospice		Lab	
Skilled Nursing		Mental Health	
Other		Other	

Billing Contact Name		Fax #	
Phone #		e-mail Address	

(4) Clearinghouse Information (Completed by Clearinghouse):

Clearinghouse ID#		Clearinghouse Name:	Emdeon
Phone #	800-845-6592	Fax #	615-885-3713
• Contact Name • E-mail Address	payerregistration@emdeon.com	Date Request Completed	
CIGNA Internal Use Only:	Date Request Received:		