

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 <i>(Emdeon certified vendor used to submit files to Emdeon)</i>					
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:					
<ul style="list-style-type: none"> 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 					
A voided blank check or bank authorization letter is required for the account receiving the direct deposit. Deposit slips are NOT accepted under any circumstances.					
EMDEON REVISION FORM DATE:					



**ERA/EFT
Enrollment Form**

Please return All Completed Forms to:

UniCare

ATTN: EDI Services CAAC07-077B

21555 Oxnard Street, Woodland Hills, CA 91367-4943

EDI Technical Support: (877) 210-4083, Fax: (818) 234-9966

edienroll-ca@wellpoint.com

Incomplete enrollment packages will cause delay.

Please print clearly. A separate form is required for each Tax Identification Number.

Provider Name: _____

Tax ID #: _____ NPI #: _____ Medicare #: _____

Physical Address: _____ City: _____ State: _____ ZIP: _____

Contact Name: _____ Title: _____

Email: _____ Phone: _____ Fax: _____

Please indicate method of retrieval for your UniCare Electronic Remittance Advice (ERA) file:

- We are a direct claim submitter and will download our own ERA files.
Our electronic mailbox ID is (ex: UN12345P) _____
Our ERA translation software is _____
- Please assign a new mailbox to download our own ERA files.
Our ERA translation software is _____
- We are switching vendors. Please discontinue our current ERA services with vendor: _____
- Our vendor will retrieve all ERA files for us. (Please have vendor complete the following fields.)

Vendor Name: EMDEON

Vendor Contact Name: ENROLLMENT HELP DESK

Vendor Contact Phone: 866-924-4634

Vendor Email: payerregistration@emdeon.com

*Note: Please make sure vendor is set up to receive ERA files from Anthem Blue Cross.
We cannot process this request if they are not set up.*

**A company officer must sign this form.
This is a legal document.**

PRINT NAME: _____ SIGNATURE: _____

TITLE: _____ DATE: _____ PHONE: _____



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UniCare Systems is hereby authorized to deposit payments for claims to the account listed below.

Attached to this form is a blank check for the account receiving the direct deposit.

DEPOSIT SLIPS ARE NOT ACCEPTED UNDER ANY CIRCUMSTANCES.

PROVIDER NAME (REQUIRED)	MEDICARE PROVIDER NUMBER (REQUIRED)
ADMINISTRATIVE CONTACT: (REQUIRED)	TAX ID NUMBER: (REQUIRED)
TITLE: (REQUIRED)	PHONE NUMBER: (REQUIRED)

BANK INFORMATION

NAME ON BANK ACCOUNT (REQUIRED)	
ACCOUNT TYPE (REQUIRED)	<input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS
BANK NAME (REQUIRED)	BRANCH NAME (REQUIRED)
BANK ADDRESS (REQUIRED)	BANK PHONE NUMBER (REQUIRED)
ACCOUNT NUMBER (REQUIRED)	TRANSIT/ABA NUMBER (REQUIRED)

An authorized signer on the bank account must sign this form.

This is a legal document.

PRINT NAME:
(REQUIRED) _____

SIGNATURE:
(REQUIRED) _____

TITLE:
(REQUIRED) _____

PHONE NUMBER:
(REQUIRED) _____

DATE SIGNED:
(REQUIRED) _____

FAX NUMBER: _____