

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 					
DO NOT SUBMIT ENROLLMENT DIRECT TO THE PAYER, FORM MUST BE PROCESSED BY EMDEON					
EMDEON REVISION FORM DATE:					



Health Net Electronic Remittance Advice (ERA) Provider Setup Form

Health Net Contact Information:		Telephone:	E-mail	Fax:
Northeast <input type="checkbox"/>	Arizona <input checked="" type="checkbox"/>	California <input type="checkbox"/>	Oregon <input type="checkbox"/>	Medi-Cal <input type="checkbox"/>
Add <input type="checkbox"/>	Change <input type="checkbox"/>	Delete <input type="checkbox"/>	Requested Effective Date:	
*Paper Remittance Required <input type="checkbox"/>		*No Paper Remittance <input type="checkbox"/>		
1	Receiver Information (<i>Entity receiving ERA file</i>)		Contact	
Receiver				
Address		State	Zip	
City		Fax		
Telephone		Tax ID		
Email Address				
2	Vendor Information (<i>Entity retrieving ERA file on behalf of receiver</i>)			
Vendor	Emdeon	Contact	Enrollment Help Desk	
Address	3055 Lebanon Rd., Bldg. III, Ste. 2000			
City	Nashville	State	TN	Zip 37214
Telephone	800-845-6592	Fax	615-695-0612	
Email Address	payerregistration@emdeon.com	Tax ID		
Vendor/Submitter ID	133052274	<input checked="" type="checkbox"/> Clearinghouse <input type="checkbox"/> FCH (Health Net use only)		
3	Provider Information (<i>Provider for whom ERA's will be returned</i>)			
Group/Facility Name				
Provider Name		Provider Contact		
Provider Address				
City		State	Zip	
Provider Telephone		Provider Fax		
Provider E-mail Address				
Provider SSN/Tax ID		HNT Provider ID		
<i>Provider TINS associated to the Group (if applicable)</i>				
Provider Name	Unique Provider ID	Provider ID (SSN/TIN)*		
1				
2				
3				
4				

Send Setup Notification to:
 Do Not Send Notification
 Vendor
 Billing Service/Dealer
 Facility/Provider

* Providers requesting electronic remittance advice (ERA) may continue to receive paper remittances in addition to the ERA. Health Net reserves the right to cease providing paper remittances at anytime without prior notice.
Providers must fax completed form to 1-800-677-4147.