

PAYER ID:

SUBMITTER ID:



emdeon™

Emdeon **Claims** 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 original signatures, NO stamped signatures or photocopies are accepted. • SUBMIT COMPLETED FORM TO: Emdeon Donelson Corporate Ctr Bldg 3 3055 Lebanon Pike Ste 1000 NASHVILLE, TN 37214-2230 					
ENROLLMENT FORM MUST BE PROCESSED BY EMDEON PLEASE DO NOT SUBMIT FORM DIRECT TO THE PAYER					
EMDEON REVISION FORM DATE:					

**MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM**

Maryland Medicaid needs some EDI information to exchange HIPAA transactions with you. Please provide the information below. If you are not processing your own EDI transactions, please have your Electronic Submitter assist you in completing this form, specifically with items #3 and #4.

1. This is a Select Media if New Application:
 New Application Electronic Transfer & Paper Voucher
 Change of Submitter Agent Paper Voucher Only
 Submitter Identification Form Update

2. Provider Information

a) Provider Name:	
b) Provider Address:	
c) Provider Number (must be 9 digits):	
d) National Provider Identifier (NPI #)	

3. Electronic Submitter Information

a) Submitter Name:	EMDEON
b) Submitter Address:	3055 LEBANON ROAD STE 2000 BLDG 3 NASHVILLE TN 37214
c) Submitter ID(ISA Qualifier and ISA ID):	EN1081

4. EDI Information

Please select the transactions that you want to exchange with Maryland Medicaid out of the following transactions:

CHECK	TRANSACTIONS	VERSION
	270/271 Eligibility Inquiry & Response	004010X092A1
	276/277 Claim Status & Response	004010X093A1
X	837 Health Care Claim Institutional	004010X096A1
X	837 Health Care Claim Professional	004010X098A1
	837 Health Care Claim Dental	004010X097A1
	820 Premium Payment	004010X061A1
	835 Health Care Claim Payment/Advice 835 GS Receiver ID _____ (Required, if Checked)	004010X091A1
	Receiver EDI Information (Required if different from above listed Submitter ID or if you are a Pharmacy Provider or Business Associate requesting an 835): Receiver Name: Receiver Address: ISA Qualifier and ISA ID:	

MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM

The provider, _____ hereby authorizes

PROVIDER NAME

_____ EMDEON _____, hereafter

SUBMITTER AGENT

referred to as Submitter Agent, to transmit our Medicaid claims to Maryland Medical Care Program, and further authorizes Maryland Medical Care Program to transmit to the Submitter Agent the return computer file electronic vouchers of all claims data processed, indicating paid, rejected, denied and pended claims (with error codes). The Submitter Agent agrees to protect the confidentiality of this data as required by law.

Signature of Provider

Signature of Submitter Agent

Print Name of Signature

Print Name of Signature

Telephone Number

Date

800-845-6592

Telephone Number

Date

Note: This form requires completion of all requested information and **original signatures** to be processed.

MAIL TO:

**SYSTEM LIAISON SERVICES
201 W. PRESTON ST., RM SS-18
BALTIMORE, MD 21201
ATTN: HIPAA DESK**

For Internal Use Only:

Systems Liaison Services Signature: _____

Date Received: _____