

PAYER ID:

SUBMITTER ID:



## Emdeon **Claims** Provider Information Form

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

<b>1 Provider Organization</b>					
Practice/ Facility Name		Provider Name			
Tax ID		Client ID		Site ID	
Address		City/State		Zip Code	
Contact Name					
E-mail Address		Telephone		Fax	
<b>2 Vendor</b> <i>(Emdeon certified vendor used to submit files to Emdeon)</i>					
Vendor Name		Vendor Submitter ID		Division ID	
Contact Name					
E-mail Address					
<b>3 Payer</b>					
Payer ID					
Group ID	Individual Provider ID		NPI ID		
<b>4 Confirmations</b>					
Send Emdeon Claim Confirmations To:					
Special Instructions:					
<ul style="list-style-type: none"> <li>All Payer Registration forms must contain signatures when applicable, stamped signatures or photocopies are accepted.</li> <li><b>SUBMIT COMPLETED FORM TO:</b>            Fax: (615) 231-4843            Email: <a href="mailto:batchenrollment@Emdeon.com">batchenrollment@Emdeon.com</a></li> </ul>					
<p>NEW SUBMITTER ID FORM = COMPLETE WHEN ADDING EMDEON AS A SUBMITTER            EXISTING SUBMITTER ID FORM = COMPLETE WHEN ADDING A PROVIDER TO A GROUP THAT ALREADY HAS EMDEON LISTED AS A SUBMITTER.</p>					
EMDEON REVISION FORM DATE:					



An Independent Licensee of the Blue Cross and Blue Shield Association.

**Section I.**

PRACTICE/FACILITY NAME: _____		
ADDRESS: _____		
CITY: _____	STATE: _____	ZIP: _____

**Section II.**

VENDOR/CLEARINGHOUSE NAME: <u>EMDEON</u>
CONTACT NAME: <u>KARLA DENNIS</u> BLUE CROSS VENDOR ID: <u>404</u>

**Section III.**

<u>Required Information</u>	<u>Optional Information</u>
Indicate the requested transaction(s): <input checked="" type="checkbox"/> 837 – claim (batch) <input type="checkbox"/> 270/276/278 – eligibility, claim status, and referral (real-time)	Indicate the FTP directory where audit reports should be delivered <u>if different than submitter ID:</u> <span style="border: 1px solid black; display: inline-block; width: 150px; height: 20px; vertical-align: middle;"></span>
Indicate submitter ID: <span style="border: 1px solid black; display: inline-block; padding: 2px 20px;">ENVOY002</span>	<input type="checkbox"/> Check here if a dial-up connection is needed.  <i>NOTE: A dial-up connection is not required if the FTP server is accessed through the internet or a frame relay connection.</i>

**Section IV.** (Continue provider list onto page 2 if additional space is needed.)

NAME OF PROVIDER	PROVIDER NPI	TAX ID

**Blue Cross will assign provider passwords and forward to the vendor.**

Completed form(s) should be faxed to EDI Services at 205 733-7362 or emailed to [EDIEnrollment@bcbsal.org](mailto:EDIEnrollment@bcbsal.org).

**The undersigned hereby:**

- Represents and warrants that he or she has full power and authority to execute this agreement on behalf of the health care provider identified in Section I (Provider) and to bind the Provider to the terms and conditions of this agreement;
- Authorizes Blue Cross and Blue Shield of Alabama (BCBSAL) (1) to disclose protected health information to the business associate identified in Section II (Business Associate); and (2) to return Provider passwords to Business Associate;
- Agrees to notify BCBSAL if the Business Associate changes;
- Agrees that Provider will be responsible for all electronic transactions submitted to BCBSAL by Provider, its employees, and its agents;
- Agrees that BCBSAL has the right to audit and confirm information submitted by or on behalf of Provider and shall have access to all original source documents and medical records related to Provider's submissions. All incorrect payments shall be adjusted in accordance with BCBSAL guidelines;
- Agrees that Provider will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all data from improper access; and
- Agrees to establish and maintain procedures and controls so that information concerning Blue Cross subscribers, or any information obtained from Blue Cross, shall not be used by agents, officers, or employees of the billing service except as provided by Blue Cross.

\_\_\_\_\_  
Authorized Representative of Provider

\_\_\_\_\_  
Date





Existing Submitter ID:

ENVOY002

Section I.

PRACTICE/FACILITY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

Section II.

VENDOR/CLEARINGHOUSE NAME: EMDEON

CONTACT NAME: KARLA DENNIS BLUE CROSS VENDOR ID: 404

Section III.

Indicate the requested transaction(s):  837 – claim (batch)  
 270/276/278 –eligibility, claim status, and referral (real-time)

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\_\_\_\_\_  
Authorized Representative of Provider

\_\_\_\_\_  
Date

