

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 signatures when applicable, stamped signatures or photocopies are accepted. SUBMIT COMPLETED FORM TO: Fax: (615) 231-4843 Email: batchenrollment@Emdeon.com 					
EMDEON REVISION FORM DATE:					

This Rider permits the electronic generation of claims that will be acceptable to the Department in lieu of written claims. This Rider sets forth requirements under which the Provider and the Department will operate:

- Section A: Responsibilities of the Provider
- Section B: Responsibilities of the Department
- Section C: Ratification

Section A

Provider's Responsibilities

1. The Provider agrees to submit claims to the Department only in the format specified by the Department.
2. The Provider agrees that the Department, Secretary of Health and Human Services or designees have the right to audit and confirm information submitted by the Provider and shall have access to all original source documents, including medical and financial records.
3. The Provider agrees to research and correct any and all discrepant claims submitted to the Department.
4. The Provider agrees to assume the responsibility to prepare or submit claims and to be solely responsible for errors, omissions and liabilities, regardless of whether claims are submitted by the Provider or by a billing agent.
5. The Provider agrees to assume all costs of hardware and software needed to facilitate the submission of electronic media claims (EMC).
6. The Provider will furnish to the Department the name of the billing agent, the telephone number, and a contact person in the event a billing agent is used for the submission of EMC.
7. The Provider acknowledges that the Provider or the Department may terminate this Rider with a 30-day written notice to the other party.

Section B

Department's Responsibilities

The Department agrees to furnish the Provider with the specifications for submission of electronic media claims.

The Department agrees to maintain a phone line to send and receive data and a separate phone line which the Provider may use to address any issues or problems related to claims submission, claims processing and/or remittance information.

The Department agrees to produce data on paid/denied claims. Processed claims will be listed on each remittance statement and sent directly to the Provider for purposes of comparison and verification.

The Department acknowledges that the Department or the Provider may terminate this Rider with a 30-day written notice to the other party.

Section C

Ratification

In witness whereof, and as consent to this Rider, the parties herein have executed this Rider and ratified it by their signatures found below:

By:

_____	_____
Provider's Signature	Date
_____	_____
Provider's Name (printed)	Title
_____	_____
Facility Name	Provider number
_____	_____
E-Mail Address	Phone Number

If using a billing service, please provide the following: (please do not list your software vendor)

EMDEON	866.924.4634
_____	_____
Name of billing service	Phone number
ENROLLMENT HELP DESK	428220000
_____	_____
Contact person	User ID

By:

Department of Health and Human Services	_____
_____	_____
Department Signature	Date
_____	_____
Department Signature	Title

Please give us information about your software

Hyperterminal _____

PROCOMMPlus4.8 _____

Other: _____

Confirmation information: *If you are billing directly to the state, you must choose one of these options.*

Phone number of computer to receive call: _____

Email address of person to receive report: _____

Fax number: _____

11. Instructions for Completing the Servicing Providers and Locum Tenens Form