

PAYER ID:

SUBMITTER ID:



# 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 *(Emdeon certified vendor used to submit files to Emdeon)*

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:

- 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

--

EMDEON REVISION FORM DATE:



5. Each party is solely responsible for the preservation, privacy, and security of data in its possession, including data in transmissions received from the other party and other persons. If either party receives from the other data not intended for it, the receiving party will immediately notify the sender to arrange for its return, re-transmission, or destruction, as the other party directs.
6. Termination or expiration of this Agreement or any other contract between the parties does not relieve either party of its obligations under this Agreement and under federal and state laws and regulations pertaining to the privacy and security of Individually Identifiable Health Information nor its obligations regarding the confidentiality of proprietary information.
7. The Trading Partner may authorize one or more intermediaries to electronically send or receive MassHealth data on its behalf. Every such intermediary must first be bound by written agreement with the Trading Partner to comply with applicable law and regulations, with the current applicable Specifications Addenda and Companion Guides, and with the terms of this Agreement. The Trading Partner agrees and represents that it will disclose its provider number, user ID number, password, and any other means that enable MassHealth data to be transmitted to or received from MassHealth, only to intermediaries with whom it has such agreements, or to members of its workforce, whom the Trading Partner has authorized to receive and transmit data on its behalf. The Trading Partner will be bound by and responsible for the acts and omissions of all such persons in the exchange of electronic data with MassHealth. The Trading Partner shall notify MassHealth of any event, such as the termination of its relationship with a previously authorized employee or intermediary, that may require action to foreclose submission and receipt of transactions by persons no longer authorized by the Trading Partner to act on its behalf. Use of an intermediary shall not relieve the Trading Partner of any risks or obligations assumed by it under this or any other agreement with MassHealth, or under applicable law and regulations. The Trading Partner will bear all costs resulting from its use of intermediaries.
8. This Agreement shall take effect and be binding on the Trading Partner and MassHealth when signed by the Trading Partner and received by MassHealth. In case of conflict between this Agreement and any prior contracts between the parties, including prior versions of this Agreement, this Agreement will prevail.

---

Trading Partner Authorized Signature  
[manual signature required – no facsimile]

---

Printed Name of Signer

---

Date

---

Telephone Number

---

E-mail Address

**Instructions:**

1. This letter must be typed on the provider's original **letterhead**.
2. Fill in information in the parentheses as it pertains to you. For group practices, be sure to include the group information **as well as** a list of each individual provider within the group and their individual id numbers.

**(Provider's Letterhead)**

(Date)

Attn: MassHealth Customer Svc.,  
75 Sgt. William B. Terry Dr.  
Hingham, MA 02043

Dear Enrollment,

Please consider this letter as authorizing Emdeon (**Payer ID 12K14**) to submit Electronic Claims with Emdeon's submitter id of 110076362A on behalf of:

(Provider Name)

(Billing Address)

(Medi-cal Provider ID)

(NPI ID) optional

(Tax ID)

Sincerely,

**(Provider's Signature)**

**\*\*\*EXAMPLE ONLY\*\*\* PRINT TO LETTERHEAD\*\*\***