

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 *(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:	
<p>Special Instructions:</p> <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 	
EMDEON REVISION FORM DATE:	

**DELAWARE TITLE XIX
ELECTRONIC CLAIM SUBMISSION
TRADING PARTNER AGREEMENT**

TYPE OF
AUTHORIZATION:

Please specify:	New <input type="checkbox"/>	Change <input type="checkbox"/>	Cancel <input type="checkbox"/>
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Electronic Data Systems has developed, under authority granted by the State of Delaware Medicaid Program, a claim processing system to facilitate business transactions by electronically transmitting and receiving data in lieu of conventional paper-based documents.

This Agreement is made by and between the State of Delaware's Department of Health and Social Services, its fiscal agent, Electronic Data Systems (hereinafter referred to as EDS), and the undersigned provider (hereinafter referred to as Provider and/or Trading Partner):

Provider:	_____
NPI:	_____
Provider's Address:	_____ _____
Contact Person:	_____
Contact Phone:	_____
Email Address:	_____

1. EDS operates and maintains, under the authority of the Department of Health and Social Services, a paperless transaction system that allows providers to submit electronic transactions through the use of designated electronic media in compliance with current EDS electronic claim specifications and any revisions that may occur from time to time.
2. The Trading Partner agrees that it will complete, to the specifications and satisfaction of EDS, adequate testing appropriate to the electronic transactions it intends to submit, and further agrees that it will correct transaction errors or deficiencies as identified by EDS.
3. The Trading Partner attests that all services for which reimbursement will be claimed shall be provided in accordance with all federal and state laws pertaining to the Delaware Medical Assistance Program, and that all charges submitted shall not exceed the Provider's usual and customary charges for the same services and items provided to persons not entitled to receive benefits under the Delaware Medical Assistance Program.
4. The Trading Partner agrees that any payments made in satisfaction of claims submitted electronically will be delivered from federal and state funds and that any false claims, statements or documents, or concealments of a material fact may be subject to prosecution under federal and state law.

5. The Trading Partner shall allow EDS access to its claims data. Further, the Trading Partner shall take reasonable steps to insure that the claims data will be submitted only by authorized personnel.
6. The Trading Partner will institute and adhere to security procedures to prevent unauthorized access to data, data transmissions, security access codes, and any and all other private or protected data or records. Further, the Trading Partner will promptly notify EDS of any unlawful use or unintended disclosure of Protected Health Information or any unauthorized attempt to obtain access to or otherwise tamper with any protected data. In the event that any litigation arises concerning the unlawful or unauthorized disclosure or use of Protected Health Information, the Trading Partner will comply with requests for cooperation from EDS and the Department of Health and Social Services.
7. The Trading Partner agrees that electronic transmission of all data shall be in strict accordance with the standards set forth in this agreement; Electronic Claim Submission guidelines as put forth by EDS; and as defined by the Health Insurance Portability and Accountability Act. In the event that electronic transmission of data fails to comply with the above stated specifications, EDS may, with the approval of the Department of Health and Social Services, terminate this agreement upon written notice to the Trading Partner.
8. The Provider may modify its election to use, not use, or change a third-party service provider such as a billing agent or authorized vendor but understands that in the event that any such modification is made, it is incumbent upon the Provider to give written notice to EDS by submitting a new Trading Partner Agreement specifying that said change is being authorized. Regardless of any such change to a third-party service provider, all elements of this Trading Partner Agreement shall remain in effect and apply to all electronic transactions.
9. The Trading Partner understands and agrees that all other terms and conditions of participation in the Delaware Medical Assistance Program remain in effect and are unchanged by this Trading Partner Agreement.
10. Please specify if a billing agent or an authorized vendor will be used to submit claims:

BILLING AGENT	
Name of Agent:	_____
Address:	_____
Contact:	_____
Telephone:	_____

AUTHORIZED VENDOR	
Name of Vendor:	EMDEON
Address:	3055 LEBANON PIKE STE 1000
Contact:	ENROLLMENT HELP DESK
Telephone:	866.924.4634
Submitter ID:	345564169

AUTHORIZATION TO SUBMIT ELECTRONIC CLAIMS

PROVIDER:

I hereby certify that I have examined this agreement and that the representations that are contained herein are true and correct. I hereby authorize the below stated individuals to submit electronic claims on my behalf to the State of Delaware Medicaid Program. I agree to notify EDS, in writing, of any changes to this agreement.

Signature: _____

Printed Name: _____

PERSONS AUTHORIZED TO SUBMIT CLAIMS ELECTRONICALLY:

I accept responsibility for the accuracy of electronic claims submitted to Medicaid and understand that any and all identification numbers used to submit electronic transactions are to remain confidential. I understand that failure to maintain confidentiality may result in falsified claims and may lead to criminal prosecution.

Signature: _____

Printed Name: _____

Signature: _____

Printed Name: _____

Signature: _____

Printed Name: _____

Signature: _____

Printed Name: _____

DEPARTMENT OF HEALTH AND SOCIAL SERVICES:

Approved by: _____

Date: _____