

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:					



NHIC, Corp MEDICARE PART A
EDI PROVIDER AUTHORIZATION FORM FOR THIRD-PARTY BILLING
 (This form is to be submitted by providers to authorize a third-party billing service or clearinghouse to perform EDI transactions on the provider's behalf)

I hereby request the Submitter and/or Receiver named below be allowed to perform the following functions on behalf of the provider number(s) listed below (check all that apply):

SECTION I: Select Transactions Authorized for this Submitter					
<input checked="" type="checkbox"/>	ASC X12 837 Claim V4010A1				
	ASC X12 276/277 Claim Status Inquiry & Response V4010A1				
	ASC X12 835 Electronic Remittance Advice V4010A1				
SECTION II: Submitter and/or Receiver Information					
Submitter Name			EMDEON		
Submitter ID			MEWEBMD0		
Street Address			3055 LEBANON PIKE, STE 1000		
City	NASHVILLE	State	TN	Zip Code	37214
Contact Name			ENROLLMENT HELP DESK		
Contact Phone Number			866.924.4634		
Contact Email Address			payerregistration@emdeon.com		
Operating as a: (select one)					
<input checked="" type="checkbox"/>	Clearinghouse				
	Billing Service				
SECTION III: Provider Information					
Provider Name					
Street Address					
City		State		Zip Code	
Contact Name					
Contact Phone Number					
Contact Email Address					
PTAN(s)	NPI(s)	PTAN(s)	NPI(s)		



SECTION IV: Contractor Codes (Select appropriate code)		
X	14101	Maine
	14004	HHH-A
	14201	Massachusetts
	14301	New Hampshire
	14401	Rhode Island
	14501	Vermont

Authorized Provider Signature	
Print Provider Signature	
Title	
Date	
The person signing this form understands the provider is responsible for the data submitted by the third-party submitter and received by the third-party receiver. If the data is mishandled in any way, the provider will be held responsible. The third-party is prohibited from viewing, storing, modifying, or reporting the data for their own use.	

Verify that all fields have been filled out accurately. Mistakes could delay processing significantly.

The form must be printed, signed, dated, and then faxed to:

NHIC, Corp
J14 PART A EDI ENROLLMENT
Fax Number: 781-741-3523

Forms received that are not signed, and dated will not be processed.

May 15, 2009