

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:					

HealthPartners – Minnesota
Electronic Registration Request

Payer ID SX009 (Professional)

Payer ID 12X51 (Institutional)

The Payer has requested the following information to be completed prior to exchanging data electronically through Emdeon. All requested information is required unless otherwise specified.

Please check which electronic transaction you are interested in exchanging:

Professional Claims____ **Institutional Claims**____

LEGAL NAME:

(The name associated to your Tax ID as defined by the IRS)

BILLING PROVIDER NAME:

(The name of the group or facility submitting the claim)

Is your practice filing claim as a **Group** or **Individual?**

BILLING ADDRESS:

(The address where claims information and payments should be sent for this NPI)

BILLING TAX ID:

BILLING NPI:

(The NPI of the group/facility submitting the claim. Please complete a separate enrollment form for each organizational subpart).

PAY-TO NPI

(Please complete if the Pay-To NPI is different than the Billing NPI).

CONTACT PERSON:

E-MAIL ADDRESS:

PHONE NUMBER: