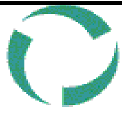
PAYER ID: SUBMITTER ID:



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 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:

Electronic Data Interchange (EDI) Provider Enrollment Form

SECTION I: Provider Information

Practice/ Facility Name:		NPI Type II: (required)
Primary Physical Address: County:	Remittance Address:	
Contact Person:		
Practice/Facility EDI Contact Person e-mail address: **(required)**		
Practice/Facility Telephone #:	Practice/Facility Tax ID#:	
Type of Practice (indicate with an X): Group: ☐ Solo: ☐ N/A: ☐		

SECTION II: Requesting the following ASC X12 HIPAA transactions (place an " X" in each applicable box)

837 I (Claim: Institutional) ☐	**276/277** (Claim Status Request and Response) ☐ (BATCH PROCESS ONLY)
837 P (Claim: Professional) ☐	**278** (Services Review-Request for Review and Response) ☐ (BATCH PROCESS ONLY)
270/271 (Eligibility/Benefit Inquiry and Response) ☐ (BATCH PROCESS ONLY)	

SECTION III: EDI Software Vendor/Billing Company/EDI Clearinghouse/Practice Management System Information

Name of EDI Software Vendor (if applicable):	Telephone #:
Name of Billing Company (if applicable):	Telephone #:
Name of EDI Clearinghouse if other than WebMD (if applicable):	
Name of Practice Management System (if applicable):	Telephone #:
Provider EDI Contact Person:	Telephone #:

SECTION IV: Provider/Facility Enrollment

(Within your organization or practice, please list each entity or provider permitted to submit claims under the Tax ID# as listed in Section I. If more than 6 entries are made, please make a copy of this form to complete the remaining entries.)

Providers submitting UB04 claim forms:	Providers submitting CMS1500 claim forms:
Provider/Facility Name:	Provider Name & Credentials (if applicable):
NPI Type II: (required)	NPI Type I: (required)
Provider/Facility Name:	Provider Name & Credentials (if applicable):
NPI Type II: (required)	NPI Type I: (required)
Provider/Facility Name:	Provider Name & Credentials (if applicable):
NPI Type II: (required)	NPI Type I: (required)
Provider/Facility Name:	Provider Name & Credentials (if applicable):
NPI Type II: (required)	NPI Type I: (required)
Provider/Facility Name:	Provider Name & Credentials (if applicable):
NPI Type II: (required)	NPI Type I: (required)
Provider/Facility Name:	Provider Name & Credentials (if applicable):
NPI Type II: (required)	NPI Type I: (required)

Geisinger Health Plan, Geisinger Indemnity Insurance Company, and Geisinger Quality Options, Inc. (herein referred to as "Health Plan")

Attestation: Geisinger Health Plan (EDI) Provider Enrollment Form

I hereby apply to the Health Plan for the purpose of electronic exchange of data including, but not limited to, the minimum necessary protected health information (as defined under the Health Insurance Portability Accountability Act of 1996) between the Health Plan and myself, or my authorized agent related to electronic data exchange transactions. Upon processing by the Health Plan, the information on this form shall be [activated] and the parties hereunder may begin the electronic exchange of such data through a Certified Software Vendor. I, or my authorized agent, agree to notify the Health Plan within five (5) business days of learning of any change to the information contained within this application. Either the Health Plan or I may terminate the electronic exchange of data at any time, upon prior notification to the non-terminating party. The information contained within this application is true, correct and complete in all respects to the best of my knowledge and belief. I understand that the misrepresentation of any material fact by me on this application could constitute grounds for termination of the transmission, receipt or otherwise access of electronic exchange of data between the parties.

_______________________________________   ____________________

Signature of Provider/Facility [Applicant]   Date

835 Remittance - Electronic Explanation of Claim Payment
Provider Enrollment Form

SECTION I: Provider Information

Practice/ Facility Name:	NPI Type II: **(required)**
Primary Physical Address:	
Contact Person:	
Practice/Facility Contact Person e-mail address: **(required)**	
Practice/Facility Telephone #:	Practice/Facility Tax ID#: **(required)**

SECTION II: Type of Transaction requested (select only one and fill out the corresponding information)

☐ **Direct** Complete only section **A.**

☐ **Clearinghouse** Complete only section **B.**

Section A. Direct Transaction

For a direct transaction all the following must be reviewed and answered:

1. What client FTP access protocol will you be using? [We support HTTPS (any web browser), FTPS (FTP + SSL) and SFTP (SSH access)].

   ____

2. What client FTP software will you be using?

   ____

3. We will PGP encrypt all outgoing files. Will you be able to provide your PGP public key (we will request this in via email at a future time)? ☐ Yes or ☐ No

Please provide:

Technical contact name: ______________________________

Email address: ______________________________

Phone number: ______________________________

If you are unable to provide all the information requested in this section a direct transmission may not be your best option.

Section B. Clearinghouse Information

Choose one of the following clearinghouses:

☐ **P N C Bank** (preferred)

☐ **Siemens**

☐ **CPSI**

☐ **Emdeon**

Please note that we will only transmit to these clearinghouses. If you utilize a different clearinghouse have them contact one of the above clearinghouses we utilize to receive your 835 transaction.

By signing below you authorize Geisinger Health Plan and it's affiliates to release our claim payment information to the marked clearinghouse in an electronic HIPAA compliant 835 transaction.

Authorized Signature: ______________________________

Print Name: ______________________________

Title: ______________________________

Date: ______________________________

Form can be faxed to 570-271-5297 – **Prior to final set up original signature page must be returned to**:
Geisinger Health Plan, Dept 32-20, 100 North Academy Avenue, Danville Pa 17822-3022