

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:					

HSM Electronic Claims Enrollment Form - Emdeon

To register with HSM, Inc to submit claims electronically please complete this form and return to Emdeon.

Date: _____

Clinic Name: _____

Electronic Claims Contact: _____

Phone: _____

Email: _____

Clinic/Payee Tax ID #: _____ NPI: _____

Provider(s): _____ NPI: _____

_____ NPI: _____

_____ NPI: _____

_____ NPI: _____

_____ NPI: _____

FOR HSM INTERNAL USE

_____ APPROVED

_____ DENIED

Reason for Denial _____

Date: _____ Name: _____