

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:					



HEALTH PLAN OF ARIZONA

LifeWise Health Plan of Arizona Provider Information Form

Provider Name: _____ Submitter ID (Assigned by LifeWise) _____

Mailing Address: _____

City/State/Zip: _____

Tax ID: _____

Contact: _____

Phone: _____ Fax: _____

Office Manager: _____

Phone: _____ Fax: _____

Email Address: _____

Claim Format: ANSI 837

Clearinghouse Name: Emdeon

Clearinghouse Number: 1LC05

LifeWise Health Plan
Attn: EDI M/S 640
P.O. 7709
Bend, OR 97708-7709
Fax: 541-318-2337
Phone: 1-800-435-2715 option 3