

PAYER ID:

SUBMITTER ID:



emdeon™

## Emdeon **Claims** Provider Information Form

\*This form is to ensure accuracy in updating the appropriate account

<b>1 Provider Organization</b>					
Practice/ Facility Name		Provider Name			
Tax ID		Client ID		Site ID	
Address		City/State		Zip Code	
Contact Name					
E-mail Address		Telephone		Fax	
<b>2 Vendor</b> <i>(Emdeon certified vendor used to submit files to Emdeon)</i>					
Vendor Name		Vendor Submitter ID		Division ID	
Contact Name					
E-mail Address					
<b>3 Payer</b>					
Payer ID					
Group ID	Individual Provider ID		NPI ID		
<b>4 Confirmations</b>					
Send Emdeon Claim Confirmations To:					
Special Instructions:					
<ul style="list-style-type: none"> <li>All Payer Registration forms must contain signatures when applicable, stamped signatures or photocopies are accepted.</li> <li><b>SUBMIT COMPLETED FORM TO:</b>            Fax: (615) 231-4843            Email: <a href="mailto:batchenrollment@Emdeon.com">batchenrollment@Emdeon.com</a></li> </ul>					
EMDEON REVISION FORM DATE:					





Hawaii Department of Human Services  
**ELECTRONIC DATA INTERCHANGE**  
**TRADING PARTNER ENROLLMENT FORM**

**B. SUBMISSION METHOD**

**B1. Please check the appropriate Submitter, Format and Transaction type(s) below:**

Submitter Type		Format and Transaction Type	
<input type="checkbox"/>	I am a provider who will submit and retrieve my response via the WINASAP2003 Software.	<input checked="" type="checkbox"/>	X12N 837 Professional
<input checked="" type="checkbox"/>	My Billing Agent will submit to ACS and retrieve responses on my behalf using WINASAP2003.	<input type="checkbox"/>	X12N 837 Institutional
		<input type="checkbox"/>	X12N 837 Dental

Please return complete forms via Mail or FAX to: **(808) 952-5595**  
**ACS EDI ENROLLMENT DEPARTMENT 1440 Kapiolani Blvd. Suite 1400 Honolulu, HI 96814**  
(Incomplete forms will cause a delay in processing and are subject to return.)