

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: