

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:					



**ACS EDI Gateway, Inc.
Commercial Division
BrickStreet Trading Partner Enrollment Form**



If you are a provider and plan to have a billing agent or clearinghouse submit any transactions on your behalf, you **DO NOT** have to fill out this form. Please contact your billing agent or clearinghouse and have them complete this form.

Form Instructions

To fill out this form electronically and submit by e-mail, please click on the appropriate selections and type in the requested information in the appropriate locations. Once the form has been completed, print a copy for your records and select the 'E-MAIL COMPLETED FORM' button on the last page of this document. This will initiate your e-mail program to open a message addressed to ACS EDI Gateway with the completed form attached. If you wish to retain an electronic copy of this completed form, CC to your e-mail address. Adobe Reader does not permit you to save your entries in the form.

If you do not have e-mail capability, you may fax the form to 850.201.1299, Attn: EDI Enrollment Unit.

Section A. Application Type
<input type="checkbox"/> New Submitter Application (I would like to become a trading partner with ACS EDI Commercial Division) <input type="checkbox"/> Change/Correction Application (I am a current trading partner with ACS EDI and wish to update my profile.) <input type="checkbox"/> Add Providers <i>(If you select this option, please complete sections C and H only.)</i>

Section B. Provider/Submitter Demographic Information	
<i>What type of business are you?</i>	
<input type="checkbox"/> Submitting Provider	<input type="checkbox"/> Software Vendor (SV)
<input type="checkbox"/> Clearinghouse (CH)	<input type="checkbox"/> Billing Agent (BA)
<i>Business Name</i>	
<i>Business Address</i>	
<i>City, State, and Zip</i>	
<i>Telephone Number</i>	<i>Fax Number</i>
<i>BMIC Submitter ID#</i> 08082	<i>Tax ID#</i>
<i>Contact Name</i>	<i>Contact Phone Number</i>
<i>Contact Title</i>	<i>E-mail Address</i>



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Section C. Submitting Provider, Software Vendor, Clearinghouse, or Billing Agent Trading Partner Identification Number <i>Note: Submitting Providers, Software Vendors, Clearinghouses and Billing Agents are given a uniquely assigned ACS EDI Gateway Trading Partner ID to act on behalf of health care providers.</i>	
If you are already enrolled to submit other payer claims to ACS EDI Gateway, indicate your ACS 6-digit Trading Partner ID here:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Section D. Software Vendor Information <i>If you plan to use Vendor software, complete the following information related to your software.</i>				
Software Vendor Name:		Software Product Name:		Software Version:
<input type="checkbox"/>	I plan on using the WINASAP2003 software	<input type="checkbox"/>	I will download the WINASAP2003 software	

Section E. Submission Transaction Type(s) * <i>Note: The X12 997 will be returned to all submitters sending electronic claims.</i>		
<input type="checkbox"/> X12N 837P (Professional Claim)	<input type="checkbox"/> X12N 837I (Institutional Claim)	<input type="checkbox"/> X12N 837D (Dental Claim)

Section F. Submission/Retrieval Method	
<input type="checkbox"/> FTP (File Transfer Protocol – MoveIT DMZ)	Dial-up modem (<i>WINASAP2003 users MUST select this option.</i>)

Section G. Delimiter Information (<i>WINASAP2003 users DO NOT need to complete this section</i>) <i>Provide an alternate delimiter if you are not using one of the default values listed below.</i>		
Element Delimiter to be used: <input type="text"/> <i>Default Delimiter (asterisk) *</i>	Segment Delimiter to be used: <input type="text"/> <i>Default Delimiter (tilde) ~</i>	Sub-Element Delimiter to be used: <input type="text"/> <i>Default Delimiter (colon) :</i>

