

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:					



Electronic Claims Sender Request Form

Please fax the completed form to (716) 929-1062. Please contact the E-Commerce call center at (716) 635-3911 if you have any questions.

Please indicate reason for test submission:

New EDI Submitter Software Vendor Change Other: _____

Please indicate the transaction(s) you would like to exchange:

ANSI 837 Institutional ANSI 837 Professional ANSI 837 Dental ANSI 835 Remittance

Date of Request: _____ Office Practice Name: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____

Office Contact Person: _____ Contact Phone Number: _____

Fax Number: _____ E-Mail Address: _____

Please fill out an additional request form for each tax identification number

Office Tax Identification Number: _____

Multiple Offices with same Tax Identification Number: Yes No

Multiple Offices with multiple Sender Id's: Yes No

NPI Numbers: _____

Your Office is: Par Non-Par Your Office is: Primary Specialist Ancillary Billing Service

Will your office be using a Clearinghouse: Yes No

Clearinghouse Name: EMDEON Clearinghouse Contact: Enrollment Help Desk

Contact Phone Number: 866.924.4634 Contact E-Mail Address: payerregistration@emdeon.com

Practice Management Software: _____ Contact Person: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E-Mail Address: _____

***** Offices must continue sending production claims while testing to avoid timely filing issues.*****

*****Even if that means billing via paper forms. Signing below acknowledges notification of this.*****

I will continue billing Via: My old system Paper

Office Manager's Signature **X** _____

Test File Requirements:

1. A minimum submission of ten claims per tax identification number.
2. A sufficient claims sample reflective of routine billing.
3. If there are multiple providers within a group, claims from at least two providers are required.

***** Office Use Only *****

Sender ID: _____ Implementation Date: _____ Orientation Date: _____

Submission Method: Web Upload Dial FTP Internet FTP

S:\EDI\FORMS\ANSI INTAKE FORM 9.28.09