



## Emdeon **Realtime** Provider Information Form

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

<b>1</b>	<b>Provider Organization</b>			Customer #			
Practice/ Facility Name				Tax ID			
Provider Name							
Address				City/State			Zip Code
Contact Name							
E-mail Address				Telephone			Fax
MID				TID			TPG

<b>2</b>	<b>Payer</b>						
Payer Name/ID							
Group Provider ID				Individual Provider ID		Billing NPI	

<b>3</b>	<b>Confirmations</b>						
Send Emdeon Confirmations To:							
<p><b>Special Instructions:</b></p> <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></li> </ul> <p style="text-align: center;"> <b>Email: <a href="mailto:RTenrollment@emdeon.com">RTenrollment@emdeon.com</a></b>  <b>Fax: 615.885.3713</b> </p>							

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EMDEON REVISION FORM DATE:							
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## 4010A1 (270/271) Health Care Eligibility Benefit Inquiry and Response (Real-Time) Form Completion Instructions

These instructions will assist you in completing the 270/271 Health Care Eligibility Benefit Inquiry and Response (Real-Time), Version 4010A1 form. The information provided will be used to set your facility up for the 4010A1 version of the Health Care Eligibility Inquiry and Response transaction. All sections must be filled out. **Print legibly and complete every section as accurately as possible.** If a section is not applicable, write "N/A". If you have any additional questions, contact EDI Support Services (EDISS) at (800) 967-7902.

### INTENTIONS

1. Check the box to indicate that this form is either new or an update to an existing form.

### PROVIDER INFORMATION

2. This date indicates when the provider will be ready to begin the Health Care Eligibility Benefit Inquiry and Response transactions.
3. Provide the Federal Tax ID of the provider/facility.
4. The Lines of Business (LOB) section will indicate for which LOB this provider is billing. Fill in the appropriate blanks for each LOB with the appropriate billing/clinic number, and check the one state that applies for that LOB.

**Note: Separate 270/271 registration forms for Institutional and Professional LOB are required if requesting BOTH Institutional and Professional 270/271 transactions.** Only one billing/clinic number can be entered for each LOB. If multiple numbers need to be entered for a single LOB then a separate registration form must be completed.

### FACILITY INFORMATION

5. Fill in all of the blanks with the requested information for the provider/clinic that is applying for the Health Care Eligibility Benefit Inquiry and Response transaction.
  - a. Entity Sending/Receiving - Indicate the entity that will be sending the 270 Health Care Eligibility Benefit Inquiry and receiving the 271 Health Care Eligibility Benefit Response.

**Note: The sender and receiver of the 270/271 transactions must be the same.**

### SIGNATURE

6. The signature section needs to be filled out completely and signed by the provider. If the provider's signature is not available, someone from the organization with the authority to enter into, administer, and/or terminate contracts and make related determinations should sign. If the provider/facility has been assigned a group provider/clinic number, EDISS requires the signature of the individual who has the authority to enter into, administrate, and/or terminate contracts and make related determinations on behalf of the group.

**Exhibit A**

**270/271 Health Care Eligibility Benefit Inquiry and Response (Real-Time)**

<p><b>270/271 HEALTH CARE ELIGIBILITY BENEFIT INQUIRY AND RESPONSE (Real-Time) FORM Version 4010A1</b></p>	<p>Phone number: (800) 967-7902 Fax number: (877) 269-1472 Contact us via e-mail at: support@edissweb.com Visit our website at: www.edissweb.com</p>
<p>EDI Support Services PO Box 6729 Fargo, ND 58108-6729</p>	

The information you provide on this EDI registration is used to set your facility up for the electronic 270/271 Real-time Health Care Eligibility Benefit Inquiry and Response (Real-Time) transaction. **Print legibly and complete every section as accurately as possible.** If a section is not applicable, write "N/A". If you have any questions concerning the correct completion of the form, please contact us for assistance.

**INTENTIONS**

1. Check the appropriate box to indicate if this is a new registration form or an update to a previously submitted registration form. *(check only one)*
  - This is a new registration form. EDISS has not received a 270/271 registration from this organization.
  - This is an updated registration form. EDISS has received a 270/271 registration from this organization, but this organization wishes to update information.

**PROVIDER INFORMATION**

2. What date would you like to begin the Health Care Eligibility Benefit Inquiry and Response transactions?  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
3. Federal Tax ID: \_\_\_\_\_
4. Select all lines of business that apply. Fill in the blank with the appropriate billing provider number or clinic number. **Note: Separate 270/271 registration forms for Institutional and Professional LOB are required if requesting BOTH Institutional and Professional 270/271 transactions.**

**Professional Lines of Business**

Blue Shield *(check only one state)*  
 ND  WY ..... NPI #: \_\_\_\_\_

**Institutional Lines of Business**

Blue Cross *(check only one state)*  
 ND  WY ..... NPI #: \_\_\_\_\_

**Exhibit A**

**270/271 Health Care Eligibility Benefit Inquiry and Response (Real-Time)**

**FACILITY INFORMATION**

5. Please fill in the facility information for the provider/clinic that will be inquiring on the benefit eligibility.

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact: \_\_\_\_\_

Telephone: (        ) \_\_\_\_\_ \*Fax: (        ) \_\_\_\_\_

E-Mail: \_\_\_\_\_

\*By providing your fax number, you are consenting that your fax machine is located in a secure area that is not accessible by anyone who is not authorized to view confidential information.

**Entity Sending/Receiving - Indicate the entity that will be sending the 270 Health Care Eligibility Benefit Inquiry and receiving the 271 Health Care Eligibility Benefit Response. (check one)**

Billing Service       Clearinghouse       Provider (self)

Entity Name: \_\_\_\_\_

**SIGNATURE**

6. The completed form with an authorized signature may be either mailed or faxed to EDISS.

**As a member of this organization, I have the authority to enter into, administrate, and/or terminate contracts and make related determinations. By signing this document I verify I meet the signature requirements and authorize the set-up noted above for the 270/271 Health Care Eligibility Benefit Inquiry and Response (Real-Time) transaction.**

Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_