

PAYER Name/ID:



## Emdeon **Realtime** Provider Information Form

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

1 Provider Organization					
Practice/ Facility Name		Provider Name			
Tax ID					
Address		City/State		Zip Code	
Contact Name					
E-mail Address		Telephone		Fax	
MID		TID			
2 Payer					
Payer Name/ID					
Group PTAN		Individual PTAN		BILLING NPI ID	
3 Confirmations					
Send Emdeon Claim Confirmations To:					
Special Instructions:	<ul style="list-style-type: none"><li>• All Payer Registration forms must contain original signatures, NO stamped signatures or photocopies are accepted.</li><li>• SUBMIT COMPLETED FORM TO: Emdeon Attn: Realtime Donelson Corporate Ctr Bldg 3 3055 Lebanon Pike Ste 1000 NASHVILLE, TN 37214-2230</li></ul>				
EMDEON REVISION FORM DATE:					

## **California Medi-Cal**

**Section 1-A of the agreement has to be filled out and mailed to EDS at the address shown.**

**The signature on the agreement has to be by someone responsible for fraud purposes i.e. Doctor or Owner.**

**EDS does not notify providers that they are set up, but they are set up as soon as the application is received. It should take 5 days or less. If there is a problem after this time period, Providers may call 1-800-541-5555 or 916-636-1200 to get status.**

## **MEDI-CAL POINT OF SERVICE (POS) NETWORK AGREEMENT**

This agreement is required of all providers and non-providers (provider representatives) intending to perform eligibility verification through a POS device, CERTS, or custom applications for the POS Network.

- I (a). (The following is required only of enrolled Medi-Cal provider users of the POS Network): the California Department of Health Services (DHS) will permit the use of the California POS Network.  
(Network) by the Medi-Cal provider (Provider Name):  
\_\_\_\_\_(NPI), \_\_\_\_\_  
subject to the terms and conditions of the agreement.
- I (b). (The following is required only if intending to use a device and/or software that is not obtained through EDS): Vendor/Developer Company Name: WebMD/Envoy  
CMC Submitter Number (if applicable) \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_
- I (c). (The following is required only if non-provider users (provider representatives) of the POS Network): DHS will permit the use of the Medi-Cal California POS Network (Network) by the authorized provider representative \_\_\_\_\_  
\_\_\_\_\_(Representative) subject to the terms of this agreement. The Representative has attached to this agreement and a list of all Medi-Cal provider numbers for which that are also the authorized representative.
- II The Provider/Representative agrees to limit the usage of the Network to the following Medi-Cal eligibility and claims related-transactions as are defined in the POS Users Guide, the CERTS User Guide, or the POS Network Interface Specifications document:
- A. Verification of Medi-Cal Eligibility
  - B. Share of Cost clearance
  - C. Medi-Service reservations
  - D. Submissions of Pharmacy claims (may be preformed by providers enrolled to submit claims on the Medi-Cal pharmacy claim form)
  - E. Submission of HCFA 1500 claims (may only be preformed by provider enrolled to submit claims on the Medi-Cal medical claim form)
  - F. Submission of other transactions as may be subsequently permitted by DHS and as a documented in on or more of the user manuals identified above.
- Provider/Representative acknowledges that failure to limit the usage of the Network to the transactions described above may, at a minimum, result in DHS revoking the privilege to use the Network.
- III The Provider/Representatives agrees that the following constitutes the only authorized Methods of accessing the Network:
- A. Medi-Cal provided 950 and 800 prefix toll-free phone lines as documented  
In the POS and CERTS User Guides.
  - B. Provider or Representative-provided leased phone lines
- IV The Provider/Representative agrees to pay the following fees associated with the use of the Network:
- A. For eligibility transactions, including Share of Cost clearance and Medi-Service reservations, submitted through Medi-Cal provided toll-free phone lines, there will be no fee.

B. For Provider and/or Representative submission of pharmacy claim transactions through Medi-Call provided toll-free lines, there will be a fee of \$ .10 per approved claim transaction. An approved claim transaction is defined as a service, medical or durable equipment supply, or drug supply that is determined to be payable through the claims adjudication process of the Network. This fee will be withheld from your regular Medi-Call Claims payment.

V Provider/Representative agrees, in order for the Provider/Representative's system to be activated for submission of actual Medi-Cal eligibility of claims related transactions, to perform testing as required by DHS and as documented in the POS Network Interface Specifications document. Provider/Representative acknowledges that multiple tests may be required to activate tge full functionality of the device/software and that all testing must be successfully concluded before the device/software will be activated.

VI Provider/Representative agrees to report all malfunctions of the POS Network to EDS at the Phone number and/or address documented in the POS Network Interface Specifications document.

VII Provider/Representative acknowledges that neither DHS nor its agent is responsible for errors or problems, including problems of incompatibility, caused by hardware or software not provided by DHS.

VIII Provider Signature:

I, the undersigned, am authorized and do attest and agree to all of the terms and conditions of this agreement.

\_\_\_\_\_  
Printed Name of Signee

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

IX Non-Provider (Authorized Representative) Signature:

I, the undersigned, am authorized and do attest and agree to all of the terms and conditions of this agreement.

\_\_\_\_\_  
Printed Name of Signee

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CMC Submitter Number (if applicable): \_\_\_\_\_

Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_

**MAIL TO: EDS 3215 Prospect Park Drive Rancho Cordova, CA 95670**