



220 Burnham Street • South Windsor CT 06074  
 Vox 888-255-7293 • Fax 860-289-0055

**NEVADA MEDICAID  
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

<b>PAYER ID NUMBER</b>	CKNV1				
<b>ELECTRONIC REGISTRATIONS</b>  Agreements Required	Emdeon Business Services Provider Enrollment Form <ul style="list-style-type: none"> <li>• Please complete all requested information.</li> </ul> Service Center Authorization <ul style="list-style-type: none"> <li>• Please complete all requested information.</li> </ul>				
<b>SEND REGISTRATION FORMS TO:</b>	Emdeon 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment				
<b>ENROLLMENT CONFIRMATION</b>	Emdeon will notify the provider or their PMS vendor, as defined by the PMS vendor, when registration is complete.				
<b>CHANGING ELECTRONIC BILLING AGENTS</b>	If the Provider currently submits claims through another Billing Agent other than Emdeon each Provider must re-enroll following the procedures listed above.				
<b>CONTACT PHONE NUMBERS</b>	<table style="width: 100%; border: none;"> <tr> <td style="width: 70%;">First Health Services Corporation</td> <td style="text-align: right;">877-638-3472</td> </tr> <tr> <td>Emdeon Dental</td> <td style="text-align: right;">888-255-7293</td> </tr> </table>	First Health Services Corporation	877-638-3472	Emdeon Dental	888-255-7293
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emdeon®

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PROVIDER ENROLLMENT FORM

Insurance Carrier: **Nevada Medicaid – payer ID CKNV1**

Print/Type the following:

Provider/Organization Name: \_\_\_\_\_

Tax Identification or Social Security Number: \_\_\_\_\_  
*(Number that will be used to submit electronic claims)*

Software Vendor: \_\_\_\_\_

Group Type 2 NPI: \_\_\_\_\_  
*(if applicable)*

Name	Rendering	NPI – Type 1
_____		_____
_____		_____
_____		_____
_____		_____

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

City, State, Zip Code: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

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

## Service Center Authorization

**Purpose:** To authorize or terminate electronic transactions through a Service Center. A Service Center may be a clearinghouse or a provider business (direct submitter). Electronic transactions are processed only if authorized by the provider by use of this form. For Pharmacy transactions, contact the Technical Call Center at (800) 884-3238.



~~Mail this form to Magellan Medicaid Administration, EDI Coordinator, PO Box 30042, Reno, NV 89520-3042.~~

<b>SERVICE CENTER SOURCE:</b> Check one. Enter the business or clearinghouse name as appropriate.	
<input type="checkbox"/> I will submit claims through a clearinghouse. Clearinghouse Name: <b>CPS/WebMD Dental</b>	<b>MAGELLAN MEDICAID ADMINISTRATION USE ONLY</b> SC Code: <b>5147</b>
<input type="checkbox"/> I will submit claims directly from my business to Magellan Medicaid Administration (direct submitter). Business Name:	
<b>AUTHORIZE A TRANSACTION:</b> Check the box next to each transaction you wish to authorize.	
<i>I hereby authorize the Service Center named above to submit transactions on behalf of the provider until the provider notifies Magellan Medicaid Administration otherwise by use of this form.</i>	
<input type="checkbox"/> Eligibility Request/Response (270/271) <input type="checkbox"/> Prior Authorization Request/Response (278/278) <input type="checkbox"/> Claims Status Request/Response (276/277) <input type="checkbox"/> Electronic Remittance Advice (835)*	<input type="checkbox"/> Professional claim (CMS-1500 claim: 837P) <input type="checkbox"/> Institutional claim (UB-04 claim: 837I) <input type="checkbox"/> Dental claim (Dental Claim: 837D)
* Paper remittance advices will cease 30 days after electronic remittance advices begin. Although multiple Service Centers may submit claims for one provider, only one Service Center can receive the electronic remittance advice.	
<b>TERMINATE A TRANSACTION:</b> Check the box next to each transaction you wish to terminate.	
<i>I no longer authorize the Service Center named above to submit transactions on behalf of the provider unless the provider notifies Magellan Medicaid Administration otherwise by use of this form. (Enter the effective date below.)</i>	
<input type="checkbox"/> Eligibility Request/Response (270/271) <input type="checkbox"/> Prior Authorization Request/Response (278/278) <input type="checkbox"/> Claims Status Request/Response (276/277) <input type="checkbox"/> Electronic Remittance Advice (835)	<input type="checkbox"/> Professional claim (CMS-1500 claim: 837P) <input type="checkbox"/> Institutional claim (UB-04 claim: 837I) <input type="checkbox"/> Dental claim (Dental Claim: 837D)
<b>Effective date for termination of this transaction(s):</b>	

I understand that I am responsible for the information presented on claims that are submitted through the Service Center designated above and that all information presented on this authorization form is true, accurate, and complete. I further understand that payment and satisfaction of Nevada Medicaid and Nevada Check Up claims will be from federal and state funds and that false claims, statements, documents or concealment of material facts may be prosecuted under applicable federal and state laws.

Provider/Entity Name: \_\_\_\_\_ Phone: \_\_\_\_\_

NPI/API (one per form): \_\_\_\_\_

Federal Tax ID Number (or SSN): \_\_\_\_\_

Will you be submitting claims that have more than one payer (COB/TPL claims)?  Yes  No

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_