



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

**RHODE ISLAND MEDICAID
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

PAYER ID NUMBER	CKRI1				
ELECTRONIC REGISTRATIONS Agreements Required	Emdeon Business Services Provider Enrollment Form <ul style="list-style-type: none"> • Please supply all requested information Trading Partner Agreement <ul style="list-style-type: none"> • Please supply all requested information 				
SEND REGISTRATION FORMS TO:	<p align="center">Please mail completed forms to:</p> <p align="center">Emdeon Business Services 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment</p>				
ENROLLMENT CONFIRMATION	Emdeon Business Services will contact the Provider or their software vendor when it has received confirmation from EDS / Rhode Island Medicaid that the Provider is authorized to send electronic claims.				
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently submits claims through another Billing Agent other than Emdeon Business Services each Provider must re-enroll following the above instructions.				
CONTACT PHONE NUMBERS	<table border="0"> <tr> <td>Emdeon Business Services</td> <td align="right">888-255-7293</td> </tr> <tr> <td>Rhode Island Medicaid Provider Relations</td> <td align="right">401-784-8100</td> </tr> </table>	Emdeon Business Services	888-255-7293	Rhode Island Medicaid Provider Relations	401-784-8100
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emdeon®

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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Rhode Island Medicaid – payer ID CKRI1**

Provider/Organization Name: _____

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

Software Vendor: _____

Group Number: _____
(if applicable)

Group NPI: _____
(if applicable)

Name	Rendering Number	NPI
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____



RHODE ISLAND DEPARTMENT OF HUMAN SERVICES



Trading Partner Agreement ID Change/Add form

Once a Trading Partner Agreement (TPA) is received and processed, this form may be used to add additional billing providers to the original TPA ID assigned. This form must be received with original signatures. **No facsimile or photocopies will be accepted.**

Trading Partner Name: _____

Assigned Trading Partner ID: _____

Before mailing your signed Trading Partner Agreement to EDS for processing please verify that:

- The document is complete
- Signatures are in the appropriate areas
- You have checked the transactions that you will be submitting and receiving (See page 5 of the TPA)

ARTICLE I. MEDICAL TRANSACTION STANDARDS

Rhode Island Medical Assistance Program Transaction Standards

Selected **ASC X12N Version 4010A** standards include, as applicable, all data dictionaries, segment dictionaries and transmission controls referenced in those standards, but include only the Transaction Sets listed in the section below. The information provided will be utilized to route transactions to the Medicaid Management Information System and back to Trading Partner directories. Remittance files (835) and Pended Claims Reports (277) will be available only to one trading partner. If authorizing one Trading Partner for claims submission and another for downloads each party must complete a separate TPA.

Check all that apply:

837 Professional	277 Unsolicited Claim Status
837 Institutional	997 Functional Acknowledgement
837 Dental	835 Remittance Advice
270 Eligibility Inquiry	271 Eligibility Response
276 Claim Status Inquiry	NCPDP 1.1 Batch Pharmacy Claim Response
NCPDP 5.1 Batch	

Specify Software:

Software	Vendor
Provider Electronic Solutions	EDS
Other	

Method of Transmission: _____

Guidelines

HIPAA – Health Insurance Portability and Accountability Act. In the event of any conflict, HIPAA standards and Implementation Guides shall control.

Please list the name(s) and phone number(s) of person(s) authorized to resolve problems regarding electronic transmissions:

Name

Phone Number

Name

Phone Number

e-mail address

ARTICLE II. RHODE ISLAND MEDICAL ASSISTANCE PROVIDERS

Please list the names and the RI Medical Assistance Program provider numbers of those providers for which electronic transactions will be submitted. Each individual provider or group for whom you will be billing must sign and date the agreement below. If additional space is required to identify each provider make copies of Article II and attach.

* Please list which number (can be both) you would like linked to your Trading Partner Number

1. _____
NPI / Medical Assistance Provider Number

Provider Name: _____

Authorized Signature: _____



Date: _____

2. _____
NPI / Medical Assistance Provider Number

Provider Name: _____

Authorized Signature: _____



Date: _____

3. _____
NPI / Medical Assistance Provider Number

Provider Name: _____

Authorized Signature: _____



Date: _____

**Trading Partner Execution:
TRADING PARTNER**



Signed

Name

Title

DO NOT FAX

**Please mail this certification to the
Following address:**

EDS
Attn: EPL Coordinator
Warwick, RI 02887-2010

VOID