



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

**WYOMING MEDICAID
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

PAYER ID NUMBER	CKWY1						
ELECTRONIC REGISTRATIONS Agreements Required	Emdeon Provider Enrollment Form <ul style="list-style-type: none"> • Please complete all requested information. Wyoming Medicaid Clearinghouse Authorization Form <ul style="list-style-type: none"> • Please complete all requested information. 						
SEND REGISTRATION FORMS TO	Emdeon 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment Or Fax to: 860-289-0055						
ENROLLMENT CONFIRMATION	Emdeon will notify the provider or their PMS vendor, as defined by the PMS vendor, when registration is complete.						
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently submits claims through another Billing Agent other than Emdeon Dental each Provider must re-enroll following the procedures listed above.						
CONTACT PHONE NUMBERS	<table border="0"> <tr> <td>Wyoming Medicaid</td> <td align="right">800-251-1268</td> </tr> <tr> <td>ACS EDI Gateway, Inc.</td> <td align="right">800-672-4959</td> </tr> <tr> <td>Emdeon Dental</td> <td align="right">888-255-7293</td> </tr> </table>	Wyoming Medicaid	800-251-1268	ACS EDI Gateway, Inc.	800-672-4959	Emdeon Dental	888-255-7293
Wyoming Medicaid	800-251-1268						
ACS EDI Gateway, Inc.	800-672-4959						
Emdeon Dental	888-255-7293						



emdeon®

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

PROVIDER ENROLLMENT FORM

Insurance Carrier: **Wyoming Medicaid - payer ID CKWY1**

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 Legacy Number as assigned by the payer: _____
(if applicable)

Group Type 2 NPI: _____
(if applicable)

Rendering Provider Information

Name	Legacy Number	NPI – Type 1
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____

Wyoming Medicaid Clearinghouse Authorization Form

Note: Only pay-to/group providers need to be authorized, treating/rendering providers do not.

Provider Name	
NPI or Provider Number	
Tax – ID	
Physical Address	
City, State, Zip Code	
Telephone Number	
Fax Number	
Email Address	
Contact Name	
Contact Phone Number	
Contact Email	

Mark which transactions the clearinghouse is authorized to send/receive on your behalf:

X	X12N 5010 999 Implementation Acknowledgement (required)	X	X12N 5010 277CA Claim Acknowledgement (required)
	X12N 5010 276/277 Health Care Claim Status Request and Response		X12N 5010 270/271 Health Care Eligibility Benefit Inquiry and Response
	X12N 5010 278 Health Care Services – Request for Review and Response; Health Care Services Notification and Acknowledgement (Prior Authorizations)	X	X12N 5010 837 Health Care Claim (Professional, Institutional, and Dental)
	X12N 5010 835 Health Care Claim Payment/Advice (Remittance Advice)		

I, _____, representative of the provider above
Provider/Provider's Representative

Claims Processing Service, Inc.
dba Emdeon Dental

_____, authorize the clearinghouse _____
Name of Provider Clearinghouse Name

TPID 12203 to submit/accept the above transactions on my behalf.
Trading Partner Number

 Provider/Provider Representative Signature

 Date