

PAYER ID:

SUBMITTER ID:



Emdeon **Claims** Provider Information Form

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

1 Provider Organization

Practice/ Facility Name		Provider Name			
Tax ID		Site ID			
Address		City/State		Zip Code	
Contact Name					
E-mail Address		Telephone		Fax	

2 Vendor *(Emdeon certified vendor used to submit files to Emdeon)*

Vendor Name		Vendor Submitter ID		Division ID	
Contact Name					
E-mail Address					

3 Payer

Payer ID			
Group ID	Individual Provider ID	NPI ID	

4 Confirmations

Send Emdeon Claim Confirmations To:	
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Special Instructions: All Payer Registration forms must contain signatures when applicable, stamped signatures or photocopies are accepted.

- SUBMIT COMPLETED FORM TO:
 - Fax: (615) 231-4843
 - E-mail: batchenrollment@Emdeon.com

REVISED DATE:

Preferred Care
EDI Enrollment Form
Attention: EDI Coordinator
Fax 585.258.8071

Please Select One:

*Clearinghouse: EMDEON Billing Service: _____

Practice/Facility Information

*Name of Practice: _____

*Street Address: _____

*City: _____

*State: _____ *Zip Code: _____ *Telephone: _____ Fax: _____

*Person to Contact: _____ Title: _____

*Practice Tax ID: _____ Type of Practice: Group _____ Solo _____ (Check one)

*Email Address: _____

Provider/Facility Information:

*Name and Title of Provider

_____ NPI _____

_____ NPI _____

_____ NPI _____

_____ NPI _____

_____ NPI _____

_____ NPI _____

Technical Information

*Software Vendor: EMDEON

*Contact Name & Phone Number: ENROLLMENT HELP DESK 866-924-4635

*Contact Email Address: PAYERREGISTRATION@EMDEON.COM

Access ID: EBNS0007

*HIPPA Transaction Types (Check all that apply)

837I _____ 837P X 835 _____

* *Required Field*