

Emdeon **Claims** Provider Setup Form

Email: officeenrollment@emdeon.com
 Fax: (615) 238-0816

1 Provider Organization

Practice/ Facility Name		Provider Name		NPI	
Provider Specialty Code		Tax ID/ SSN		Site ID	
Address		City/State		Zip Code	
Contact First Name		Contact Last Name		Title	
E-mail Address		Telephone		Fax	

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

Vendor Name	<i>Emdeon Office</i>			Submitter ID	<i>223182777</i>
Contact First Name	<i>Deb</i>	Contact Last Name	<i>Holmes</i>	Title	<i>Product Manager</i>
E-mail Address	<i>officefeedback@emdeon.com</i>	Telephone	<i>877-469-3263</i>	Fax	<i>N/A</i>

3 Product Type

TSO ID <i>(if known)</i>		Communication Protocol /Output	<i>F = File Transfer</i>		
Report Type	<i>NEIC Clearinghouse Reports</i>	Emdeon Office User ID			
Report Format	<i>Human Readable (text)</i>	Paper Claims Mailed?	<i>X Yes</i>		

4 Payer

M = Medical H = Hospital Commercial

Please list additional payers below

Check the Emdeon Payer List to see if additional enrollment is required <http://www.emdeon.com/PayerLists/payerlists.php>

Payer ID	Group ID	Individual Provider ID	Payer ID	Group ID	Individual Provider ID

5 Confirmations

Send Emdeon Claim Setup Confirmations To:	<i>Provider Org (Section 1)</i>
Send Additional Claim Setup Confirmations To:	

Emdeon Internal Use Only Division ID: _____ Account ID: _____ Master Account ID: _____