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:	

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***