

**MASSACHUSETTES BCBS MEDICAL ERA****For Initial Enrollment with this payer:**

- If you have NOT submitted claims electronically to this payer, the Payer requires Payer Registration forms. **You MUST be enrolled for EDI with this payer, and have a minimum of one successful claim processed on paper before enrolling for Electronic Remittance Advice (ERA).**
- Registration with Emdeon takes 14 business days.
- Your Payer Registration form must include a valid Provider ID. Listing an invalid Provider ID will delay the process.
- This payer accepts group agreements.
- You may obtain the form from our enrollment web site <http://www.emdeon.com>.

**For Re-Enrollment (COS Change of Service) with this payer:**

- If you have submitted claims electronically to this payer in the past, either directly or through another clearinghouse, and would like to submit through Emdeon, the Payer requires payer registration forms. **You MUST be enrolled for EDI with this payer, and have a minimum of one successful claim processed on paper before enrolling for Electronic Remittance Advice (ERA).**
- Registration with Emdeon takes 14 business days.
- Your Payer Registration form must include a valid Provider ID. Listing an invalid Provider ID will delay the process.
- This payer accepts group agreements.
- You may obtain the form from our enrollment web site <http://www.emdeon.com>.

**If you are already APPROVED by this payer to submit through Emdeon:**

- If you have already received an approval from this payer to submit claims electronically through Emdeon, you must notify Emdeon so that we may process your approval in our enrollment systems. Please submit a **Client Provided Approval Form** to Enrollment for processing.
  - You may obtain the form from our enrollment web site <http://www.Emdeon.com> or by calling our Fax on Demand service at 1-800-760-2804 (doc# 1450).
  - The Client Provided Approval form must be submitted to: [payerregistration@Emdeon.com](mailto:payerregistration@Emdeon.com) , or faxed to 615-885-3713.

**Payer Registration Reminders:**

- Please keep a copy of all forms for your records.
- Please verify that all pages in the agreement are included when mailing.
- Please ensure that all required fields are completed and legible.
- Please provide a physical address below in case we need to Fed-Ex your agreement back to you.
- Please remember to sign and date all documents. Your software vendor must be certified to send All-Payer claims to Emdeon. Please contact your vendor if you have questions regarding certification.
- To obtain forms or additional payer information, visit our website: <http://www.Emdeon.com>.


**MASSACHUSETTES BCBS MEDICAL ERA**
**Instructions for submitting Payer Registration Forms:**

- You must include this page when submitting Payer Registration forms to Emdeon
- Registration forms must be submitted to the address or fax number below
- To obtain forms or additional payer information, visit our website: <http://www.Emdeon.com>.

This Registration form is for a: <input type="checkbox"/> Provider <input type="checkbox"/> Group			
Name*			
Physical Address*			
City, State, Zip*			
Contact Name*			
Contact Phone			
Contact Fax			
Contact Email Address §			
<input type="checkbox"/> NPI ID*	<input type="checkbox"/> Group ID*		
	<input type="checkbox"/> Provider ID*		
<input type="checkbox"/> Tax ID* <input type="checkbox"/> SSN	Site ID*		
Vendor Submitter ID*	203506468	Division ID*	
Vendor Name*	Signature Claims		
Additional Info			

\* Required Information if applicable.

§ All Approval Notifications will be sent to this address

**Submit Original Payer Registration forms that require original signatures to:**

Emdeon Business Services  
 Attn: Enrollment Dept  
 Donelson Corporate Ctr Bldg 3  
 3055 Lebanon Pike Ste 2000  
 Nashville, TN 37214

**For all other forms:**

**Fax:** (615) 231-4843

**Email:** [batchenrollment@Emdeon.com](mailto:batchenrollment@Emdeon.com)

**To avoid claim rejection, please do not submit electronic claims before receiving [Emdeon Approval Notification](#).**

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**Instructions:**

1. **This letter must be typed on Provider's Original Letterhead.**
  2. Fill in the information in the parentheses as it pertains to you.
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**(PROVIDER'S LETTERHEAD)**

**EMDEON AUTHORIZATION LETTER**

(DATE)

Emdeon  
Attn: EMC Enrollment  
316 Summer Street , 3rd Floor  
Boston, MA 02210

Dear EMC Enrollment:

Please consider this letter a confirmation that **(Provider's Name, Address and BCBSMA Provider Number)** authorizes **Emdeon** to receive BCBSMA payment information (electronic remittance) electronically.

Sincerely,

**(Provider's Signature)**

**Submitter's ERA Vendor Source Code: U076**

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**FACSIMILE TRANSMITTAL SHEET**

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To: EMC Enrollment

From:

Fax: 617-761-3991

Pages: (including this one)

Phone: 800-266-2206 option 6, option 3

Date:

Re: EMC Enrollment Paperwork

Fax:

Phone:

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URGENT

FOR REVIEW

PLEASE COMMENT

PLEASE REPLY

PLEASE RECYCLE

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NOTES/COMMENTS:

This facsimile contains PRIVILEGED and CONFIDENTIAL information intended only for the use of the specific individual or entity named above. If you or your employer is not the intended recipient of this facsimile or an employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any unauthorized dissemination or copying of this facsimile or the information contained in it is strictly prohibited. If you have received this facsimile in error, please immediately notify the sender named above at once by telephone. Thank you.