

10/31/2008



Provider Payer Notification Form

PAYER ID		CLAIMS		ERA	
1		Provider Organization			
Practice Name		Provider Name			
Tax ID	Site ID	**Client id			
PROVIDER ID	GROUP ID	NPI			
ADDRESS					
CITY, STATE, ZIP					
Contact Name	Contact phone				
*Payer Assigned submitter ID					
Additional Information					

***APPLICIBLE PAYERS ONLY**

**** Claim Master customers required**

To avoid claim rejection, please do not submit claims before receiving Emdeon Response Notification.

Submit faxes and email to:

Fax: (615)231-4843

Email: payerregistration@emdeon.com

