P.O. Box 7011 Northridge, Ca 91327-7011 * (818) 368-5501 * www.signatureclaims.net

Provider Sign-up Form Information

Emdeon Special
(Gov't Claims only)

Use this form ***ONLY*** if directed to for special government claims that are sent via Emdeon.

Completely fill in Section 1, Section 3 and Section 5.

Complete and fax this form to:

(615)885-3713

EMAIL to: batchenrollment@emdeon.com
Or FAX : (615) 885-3713

BATCH CLAIMS PROVIDER SET UP FORM

CLAIMS TYPE: ☒ **Medical** ☐ **Hospital** ☐ **Dental**

Revised 0305

1 REIMBURSEMENT INFORMATION (*Facility or Provider/Group*)

Pay to Name
Pay to Address
City: State Zip Code
Contact Phone
Fax E-mail Address
ID# for Claims Submission ☐TAX ID ☐SSN Site ID 0001
Billing Account Type X Vendor ☐ Provider/Group ☐ Facility ☐ Billing Service/Dealer

2 PRODUCT TYPE (*Product used to Submit Batch Claims to WebMD*) *Check only one box*

☐ WebMD Certified Vendor: TSO ID *EDFK* Communication Protocol *COMMSERVER*
Vendor/Submitter ID *203506468* Vendor Report Format *PRINT READABLE*
Xpedite Customer Number (WebMD USE
☐Xpedite ONLY): *10- N/A*
☐Other Product Name *N/A* Customer #/User ID N/A

3 FACILITY/PROVIDER INFORMATION

Facility/Group Name
Provider Name Title
Mailing Address
City State Zip Code
Street Address
City State Zip Code
Site ID 0001 *(if necessary)* Tax ID
Provider Specialty Code Type of Practice Code SSN
UPIN License # State

4 INSTITUTIONAL (UB92) PAYER SELECTION LIST

☐ Commercial:
☐ Paper: Check here if you want WebMD to print & mail paper claims for you.
☐ Medicare Payer ID State Hospital Primary# _ _____ Hospital Secondary# _ _____
☐ Medicaid Payer ID State Hospital Primary# _ _____
☐ Tricare Payer ID State Hospital Primary# _ _____ Region _ ____
☐ Blue Cross Payer ID State Hospital Primary# _ _____
☐ Medicare HomeHealth State Hospital Primary# _ _____ Hospital Secondary# _ _____

5 PROFESSIONAL (HCFA 1500) PAYER SELECTION WebMD Payer List: http://www.emdeon.com/PayerLists/payerlists.php

For payers that require additional enrollment, enter Payer ID(s) from WebMD Payer List(s). Indicate the state abbreviation and provider number(s) for each. If additional rows are required for Payer ID selection, complete additional Provider Setup forms.

☐ Commercial Payer ID Prov. ID Payer ID Prov. ID
☐ Paper: *Check here if you want WebMD to print & mail paper claims for you.*
☐ Government Payers/Blue Cross Blue Shield

Medicare Participating? ☐Yes ☐No *Will default to YES if not marked*

Payer ID State Individual # Group#
Payer ID State Individual # Group#
Payer ID State Individual # Group#
Payer ID State Individual # Group#
Payer ID State Individual # Group#

6 VENDOR/BILLING SERVICE/SOFTWARE INFORMATION

Vendor Name	Signature Claims	Billing Service	
Contact	Bill Greenland	Contact	
Address	18930 Kirkcolm Ln Northridge CA 91326	Address	
Fax	N/A	Fax	
Phone	(818) 368-5501	Phone	
E-mail	bi11@signatureclaims.net	E-mail	
Software Name	N/A	Customer #	

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Send Setup Notification to: ☐**Do Not Send Setup Notification** X **Vendor** ☐**Billing Service/Dealer** ☐**Facility/Provider**
Send Payer Correspondence and Payer Approvals to: ☐**Vendor** ☐**Billing Service/Dealer** X **Facility/Provider**

For Payer Registration Forms go to: http://www.emdeon.com/PayerLists/payer_enrollment_forms.php