

MASSHEALTH (MASSACHUSETTS MEDICAID) ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

PAYER ID NUMBER	CKMA1						
ELECTRONIC REGISTRATIONS Agreements Required	Electronic Billing Submission Agreement and Certification Statement <ul style="list-style-type: none"> ▪ Please fill in the following: <ul style="list-style-type: none"> ▪ Provider Medicaid Number ▪ Provider Name ▪ Address ▪ City, State & Zip Code ▪ Telephone & Fax Numbers ▪ E-mail Address (if applicable) ▪ Original Signature ▪ Date WebMD Dental Provider Enrollment Form <ul style="list-style-type: none"> • Please complete all requested information. 						
SEND REGISTRATION FORMS TO:	Please mail or fax the completed form to: WebMD Dental 220 Burnham Street South Windsor, CT. 06074 Attn: Provider Enrollment Fax # 860-289-0055						
ENROLLMENT CONFIRMATION	<ul style="list-style-type: none"> ▪ Enrollment will be coordinated between WebMD Dental and EDS. Once approval is received, WebMD Dental will notify the provider or their software vendor. 						
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently submits claims through another Billing Agent other than WebMD Dental each Provider must re-enroll following the procedures listed above.						
CONTACT PHONE NUMBERS	<table style="width: 100%; border: none;"> <tr> <td style="width: 70%;">Medicaid Provider Enrollment: In-State</td> <td style="text-align: right;">800-325-5231</td> </tr> <tr> <td style="text-align: right;">Out-of-state</td> <td style="text-align: right;">617-628-4141</td> </tr> <tr> <td>WebMD Dental Provider Enrollment</td> <td style="text-align: right;">888-255-7293</td> </tr> </table>	Medicaid Provider Enrollment: In-State	800-325-5231	Out-of-state	617-628-4141	WebMD Dental Provider Enrollment	888-255-7293
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A service of WebMD Business Services
220 Burnham Street • South Windsor CT 06074
Vox 888-255-7293 • Fax 860-289-0055

PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **MassHealth – Massachusetts Medicaid**

Provider/Organization Name: _____

Tax Identification or Social Security Number: _____
(Number that will be used to submit electronic claims)

Software Vendor: _____

Group Number: _____

Rendering Name and Number:

_____	_____
_____	_____
_____	_____
_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____

