220 Burnham Street ● South Windsor, CT 06074
Vox 888-255-7293 ● Fax 860-289-0055

MAINE MEDICAID
ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

PAYER ID NUMBER	CKME1
ELECTRONIC REGISTRATIONS Agreements Required	**Emdeon Business Services Provider Enrollment Form** ▪ Please complete all requested information. **MaineCare Electronic Media Claims Rider** • Sec. C: Please supply Provider's signature, date, provider's name, title, office name, **billing** provider ID, and office phone number.
SEND REGISTRATION FORMS TO:	**Please mail or fax to:** Emdeon Business Services 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment Fax #: 860-289-0055
ENROLLMENT CONFIRMATION	▪ Enrollment will be coordinated between Maine Medicaid and Emdeon Business Services. Emdeon will notify the provider's software company or the provider upon completion.
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently submits claims through another Billing Agent other than Emdeon Business Services, each Provider must re-enroll following the procedures listed above.
CONTACT PHONE NUMBERS	Provider File Unit 800-321-5577 Emdeon Business Services 888-255-7293

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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Maine Medicaid**

Provider/Organization Name: _____

Tax Identification or Social Security Number: _____
(This is the 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: _____

Section B

Responsibilities of the Department

1. The Department agrees to furnish the Provider with the specifications for submission of electronic media claims.

2. The Department agrees to maintain a phone line to send and receive data and a separate phone line which the Provider may use to address any issues or problems related to claims submission, claims processing and/or remittance information.

3. The Department agrees to produce data on paid/denied claims. Processed claims will be listed on each remittance statement and sent directly to the Provider for purposes of comparison and verification.

4. The Department acknowledges that the Department or the Provider may terminate this Rider with a 30-day written notice to the other party.

Section C

Ratification

In witness whereof, and as consent to this Rider, the parties herein have executed this Rider and ratified it by their signatures found below:

By _____
Provider's Signature Date

Printed Name: _____

Title: _____

Facility Name: _____

Provider Number: _____

Phone Number: _____

If using a billing service, please provide the following:
PLEASE DO NOT LIST YOUR SOFTWARE VENDOR.

Name of billing service: _____

Phone Number: _____

Contact Person: _____
USER ID: 426210000

By _____
State Department's Signature Date

Printed Name: _____

Title: _____

Please indicate your software:
Hyperterminal: _____
PROCOMMPlus 4.8_____
Other: _____

Confirmation Report Method: ***If you are billing directly to the state***, then you must choose one of these options.

Callback (phone number of computer to receive call):
_____
Email (email address of person to receive report):
_____
FaxBack (the number to your fax machine)
_____

NOT USED