



emdeon™

business services

220 Burnham Street • South Windsor CT 06074

Vox 888-255-7293 • Fax 860-289-0055

**OHIO MEDICAID  
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

|  |   |
|--|---|
| <b>PAYER ID NUMBER</b>                                     | <b>CKOH1</b>  |
| <b>ELECTRONIC REGISTRATIONS</b><br><br>Agreements Required | <b>Emdeon Business Services Enrollment Form</b><br>Please complete all requested information. Group practices <b><u>MUST</u></b> list all rendering provider names and Medicaid provider numbers. |
| <b>SEND REGISTRATION FORMS TO:</b>                         | Please mail completed forms to:<br><br>Emdeon Business Services<br>Attn: Provider Enrollment<br>220 Burnham Street<br>South Windsor, CT. 06074<br><br>Or fax to: 860-289-0055                     |
| <b>ENROLLMENT CONFIRMATION</b>                             | Enrollment will be coordinated between Emdeon Business Services and ODJFS. Once approval is received Emdeon Business Services will notify the provider or their software vendor.                  |
| <b>CHANGING ELECTRONIC BILLING AGENTS</b>                  | If the Provider currently submits claims through another Trading Partner other than Emdeon Business Services each Provider must re-enroll following the procedures listed above.                  |
| <b>CONTACT PHONE NUMBERS</b>                               | Emdeon Business Services                      888-255-7293<br>MMIS-EDI Support:                              614-387-1212   |



Provider Enrollment Form

Print/Type the following:

Insurance Carrier: **Ohio 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: \_\_\_\_\_