400 Vermillion Street ● Hastings, MN 55033
Ph 800-482-3518 ● Fax 651-389-9152

DESERET MUTUAL BENEFIT ADMINISTRATORS
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

PAYER ID NUMBER	**CX089**
SPECIAL NOTES	**You must include a copy of your approval email from DMBA with this registration request. Change Healthcare cannot process your enrollment without this information. If you do not have a copy of your approval email, please call DMBA Provider Maintenance at (800) 777-3622 to request the approval email.**
ELECTRONIC REGISTRATIONS Agreements Required	**All enrollments for DMBA must be completed online at http://www.dmba.com/provider/EDIApplication.aspx.** **Providers are responsible for following up with DMBA on the status of their enrollment and for notifying Change Healthcare when approved. Providers should complete the Change Healthcare Dental Provider Enrollment Form and submit to Change Healthcare with a copy of their DMBA approval email.** **Information needed for completion of the online enrollments** • Emdeon's Trading Partner Number (TPN) is HT001755-022. This number MUST be listed in the Provider Information section. • In the Electronic Transaction Types section, Dental Claims (ADA 2006/J400) must be checked off.
SEND REGISTRATION FORMS TO	Fax to: 860-289-0055 Or Email to: dentalsupport@Change Healthcarecom
ENROLLMENT CONFIRMATION	**Providers are responsible for following up with DMBA on the status of their enrollment and for notifying Change Healthcare when approved. Providers should complete the Change Healthcare Dental Provider Enrollment Form and submit to Change Healthcare with a copy of their DMBA approval email.**
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently submits claims through another Billing Agent other than Change Healthcare Dental each Provider must re-enroll following the procedures listed above.
CONTACT PHONE NUMBERS	**DMBA Provider Maintenance 800-777-3622** **Change Healthcare Dental 888-255-7293**

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PROVIDER ENROLLMENT FORM

Insurance Carrier: **Deseret Mutual Benefit Administrators - payer ID CX089**

Print/Type the following:

Provider/Organization Name: ____

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

Software Vendor: ____

Group Type 2 NPI: ____
(if applicable)

Rendering Provider Information

Name	NPI – Type 1
______________________________	_____________________________________
______________________________	_____________________________________
______________________________	_____________________________________
______________________________	_____________________________________

Address: ____

City, State, Zip Code: ____

Office Contact Name: ____

Telephone Number: __________________ Fax Number: ________________

Email: ____

I have completed the online enrollment process with DMBA. I have included a copy of my approval email from DMBA with this request.

Signed: ____________________________________ Date: ___________________