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

WASHINGTON, D.C. MEDICAID
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

PAYER ID NUMBER	**CKDC1**
ELECTRONIC REGISTRATIONS **Agreements Required**	**Electronic Dental Services Provider Enrollment Form** • Please complete all requested information. **Washington, D.C. ACS EDI Provider Enrollment Form** • Please complete all requested information.
SEND REGISTRATION FORMS TO	Electronic Dental Services 400 Vermillion Street Hastings, MN 55033 Attn: Provider Enrollment Or Fax to: 800-482-3518
ENROLLMENT CONFIRMATION	Enrollment will be coordinated between Washington, D.C. Medicaid and Electronic Dental Services. Once approval is received EDS will notify the provider or their software vendor.
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently submits claims through another Billing Agent other than Electronic Dental Services each Provider must re-enroll following the procedures listed above.
CONTACT PHONE NUMBERS	ACS EDI Helpdesk 866-775-8563 Electronic Dental Services 800-482-3518

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

PROVIDER ENROLLMENT FORM

Print/Type the following:
Insurance Carrier: **Washington, D.C. - payer ID CKDC1**

Provider/Organization Name: _____

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

Software Vendor: _____

Group Number: _____
(if applicable)

Rendering Name	Rendering Number
_____	_____
_____	_____
_____	_____
_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____

Washington, D.C. ACS EDI Provider Enrollment Form

Please return to:
ACS
Attn: Technical Support/Enrollment
PO Box 34734
Washington DC 20043-4761
Or fax to: 202-906-8399

Provider ACS EDI Gateway Authorization form for Billing Agents and Clearinghouses.

Section A. Provider Information.

Please indicate your classification **(required):** ☐ Individual Provider ☐ Group Provider/Practice	
Business Person	
Provider Name (Last, First, MI and Suffix)	
Provider Number (Required for Individuals)	*Group Provider Number (Required for Groups)*
Business Address	
City, State, and Zip	
Telephone Number	*Fax Number*
Contact Name	*E-mail Address*

Section B. Authorization Signature *(required).*

Provider, _____ hereby appoints
Provider name /Provider Representative name (please print)

ENVOY LLC, EMDEON BUS SER CO, **90185**
Billing Agent/Clearinghouse name (please print) *Billing Agent/Clearinghouse ACS Trading Partner/Submitter ID*

to act as the authorized agent for the purpose of submitting health care transactions electronically to ACS EDI Gateway, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

☐ 277-Claims Status Response ☐ 271-Eligibility Response ☐ 824-Error Report
☐ 835-Healthcare Claims Payment Advice ☐ 278-Prior Authorization Response

_____
Provider/Provider Representative name (Please print)

SIGN HERE

_____
Provider/Provider Representative Signature

_____
Date