



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

**MINNESOTA MEDICAID  
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

<b>PAYER ID NUMBER</b>	<b>CKMN1</b>				
<b>ELECTRONIC REGISTRATIONS</b>  Agreements Required	<b>Electronic Dental Services Provider Enrollment Form</b> <ul style="list-style-type: none"> <li>Please complete all requested information</li> </ul>				
<b>SEND REGISTRATION FORMS TO:</b>	Please mail or fax completed forms to:  <p align="center">Electronic Dental Services      400 Vermillion Street      Hastings, MN 55033</p> <p align="center">Fax # 651-389-9152</p>				
<b>ENROLLMENT CONFIRMATION</b>	Enrollment will be coordinated between Electronic Dental Services and Minnesota Medicaid. EDS will notify the provider or their software vendor when approval is received.				
<b>CHANGING ELECTRONIC BILLING AGENTS</b>	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.				
<b>CONTACT PHONE NUMBERS</b>	<table border="0"> <tr> <td>MN Medicaid Customer Service</td> <td align="right">800-366-5411</td> </tr> <tr> <td>Electronic Dental Services</td> <td align="right">800-482-3518</td> </tr> </table>	MN Medicaid Customer Service	800-366-5411	Electronic Dental Services	800-482-3518
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### Minnesota Health Care Programs (MHCP)


# Provider Setup Form

For use by Clearinghouses, Billing Organizations and providers


Notify MHCP whenever providers/billing organizations are **added or removed** from your list. Copy as needed.

CLEARINGHOUSE/BILLING ORGANIZATION SUBMITTER ID A334726500		CLEARINGHOUSE/BILLING ORGANIZATION NAME G&C Claims Processing	
NAME OF PERSON COMPLETING THIS FORM Terri		ADDRESS 1807 Market Blvd.	
PHONE NUMBER 651-480 -8090	CITY Hastings	STATE MN	ZIP CODE 55033


## MHCP Pay-To Provider

PAY-TO PROVIDER NAME	NPI/UMPI	LINK TO CLEARINGHOUSE/BILLING ORGANIZATION SUBMITTER ID - EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER CONTACT NAME	PHONE NUMBER	REMOVE LINK TO CLEARINGHOUSE/BILLING ORGANIZATION SUBMITTER ID - EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER SIGNATURE 	DATE (MM/DD/YYYY)	CHOOSE ONE <input type="checkbox"/> Claim <input type="checkbox"/> ERA <input checked="" type="checkbox"/> Both

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Fax this form to MHCP Provider Enrollment at 651-431-7462