



1304 Vermillion Street • Hastings, MN 55033  
Ph 800-482-3518 • Fax 651-389-9152

**PENNSYLVANIA MEDICAID  
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

<b>PAYER ID NUMBER</b>	<b>CKPA1</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:  Electronic Dental Services 1304 Vermillion Street Hastings, MN 55033 Attn: Provider Enrollment  651-389-9152
<b>ENROLLMENT CONFIRMATION</b>	Upon receipt of the EDS' Dental Provider Enrollment Form, EDS will enter the provider's information into our systems and notify the provider or their software vendor when complete.
<b>CONTACT PHONE NUMBERS</b>	Pennsylvania Medicaid 717-772-6140 Electronic Dental Services 800-482-3518



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**PROVIDER ENROLLMENT FORM**

Print/Type the following:

Insurance Carrier: **Pennsylvania Medicaid – payer ID CKPA1**

Provider/Organization Name: \_\_\_\_\_

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

Software Vendor: \_\_\_\_\_

Group Number: \_\_\_\_\_  
*(if applicable)* *(Including the 4 digit location suffix)*

Group NPI: \_\_\_\_\_  
*(if applicable)*

Name	Number	Rendering	NPI
_____	_____	_____	_____

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

I authorize Emdeon Dental to attach the above information to my Pennsylvania Medicaid claims.



Provider Signature

date