



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

**IOWA MEDICAID
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

PAYER ID NUMBER	CKIA1
SPECIAL NOTES	You must include a copy of your approval from EDISS with this registration request. EDS cannot process your enrollment without this information. If you do not have a copy of your approval email or fax, please log into your EDISS TOB account and print a new copy.
ELECTRONIC REGISTRATIONS Agreements Required	<p>Per the email excerpt on the following page all enrollments for IA Medicaid must be completed online at https://connect.edissweb.com.</p> <p>Providers are responsible for following up with EDISS on the status of their enrollment and for notifying EDS when approved. Providers should complete the EDS Dental Provider Enrollment Form and submit to EDS with a copy of their EDISS approval email.</p> <p>Information needed for completion of the online enrollments</p> <ul style="list-style-type: none"> • IA Medicaid is known as MCD IA or Medicaid Iowa. • EmdeoChange Healthcare is known as Emdeon Dental. • Emdeon's ID is CH00167. • Change Healthcare is referred to as a Network Service Vendor and a Clearinghouse. • Emdeon's address is: 220 Burnham Street South Windsor, CT 06074 • Emdeon's contact is: Customer Support • Phone:888-255-7293 Fax: 860-289-0055 • Emdeon's method of electronic access is Dial Up. • Emdeon's protocol is Zmodem.
SEND ENROLLMENT FORMS TO:	E-mail: Enrollment@edsedi.com or Fax: 651-389-9152
ENROLLMENT CONFIRMATION	Providers are responsible for following up with EDISS on the status of their enrollment and for notifying EDS when approved. Providers should complete the EDS Dental Provider Enrollment Form and submit to EDS with a copy of their EDISS approval email or fax.
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently receives claims through another Billing Agent other than Electronic Dental Services each Provider must re-enroll following the procedures listed above.
CONTACT PHONE NUMBERS	EDI Support Services: 800-967-7902 Electronic Dental Services: 800-482-3518



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PROVIDER ENROLLMENT FORM

Insurance Carrier: **Iowa Medicaid - payer ID CKIA1**

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 Legacy Number as assigned by the payer: _____
(if applicable)

Group Type 2 NPI: _____
(if applicable)

Rendering Provider Information

Name	Legacy Number	NPI – Type 1
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Email: _____

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

Signed: _____

Date: _____