



400 Vermillion Street • Hastings, MN 55033  
 Ph 800-482-3518 • Fax 651-389-9152  
[www.edsedi.com](http://www.edsedi.com)

**MAINE MEDICAID / MAINCARE  
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

<b>PAYER ID NUMBER</b>	<b>CKME1 AND CKMEH</b>
<b>SPECIAL NOTES</b>	Please note enrollment is required for Maine Medicaid (MaineCare) and is completed directly with MaineCare online at: <a href="https://mainecare.maine.gov/">https://mainecare.maine.gov/</a>
<b>ELECTRONIC REGISTRATIONS</b>	Electronic Dental Services Provider Enrollment Form <ul style="list-style-type: none"> <li>• Please complete all requested information.</li> <li>• Please complete 1 sheet for each servicing location</li> </ul>
<b>SEND ENROLLMENT FORMS TO:</b>	Electronic Dental Services 400 Vermillion Street Attn: Enrollment Hastings, MN 55033 E-mail: <a href="mailto:Enrollment@edsedi.com">Enrollment@edsedi.com</a> or Fax: 651-389-9152
<b>ENROLLMENT CONFIRMATION</b>	EDS will process claims through electronically once enrollment has been completed.
<b>CHANGING ELECTRONIC BILLING AGENTS</b>	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.
<b>CONTACT PHONE NUMBERS</b>	MaineCare EDI Help Desk <span style="float: right;">866-690-5585 Opt 3</span> Electronic Dental Services <span style="float: right;">800-482-3518</span>



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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: Maine Medicaid / MaineCare - Payer IDs CKME1 CKMEH

**You must include a copy of your welcome letter from MaineCare with this registration request. EDS cannot process your enrollment without this information. If you do not have a copy of your welcome letter, please contact MaineCare at 866-690-5585 option 3 and request another copy be sent to you.**

Please Print/Type the following:

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

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

Software Vendor/Clearinghouse: EDS - Electronic Dental Services

**Type 2 NPI**

Pay to NPI: \_\_\_\_\_ Billing NPI: \_\_\_\_\_  
(if applicable)

MaineCare Service Location ID: \_\_\_\_\_

**Rendering Provider Information**

Name

Type 1 NPI

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

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

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

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

I have completed the online enrollment process with MaineCare. I am requesting Change Healthcare Dental Services store and attach above listed servicing location(s) ID to my MaineCare 837D and 837I transactions (claims).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_