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

DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

PAYER ID NUMBER	CKWA1
ELECTRONIC REGISTRATIONS Agreements Required	Effective April 23, 2010 all Provider Enrollment Applications and updates must be completed through the ProviderOne system. This online system will replace the current paper enrollment process. EDS Provider Enrollment Form • Please complete all requested information.
SPECIAL NOTES	You can learn more about how to set up security and register in ProviderOne at the following DSHS website: http://www.hca.wa.gov/medicaid/providerone/pages/index.aspx Change Healthcare Dental has registered with DSHS in the new ProviderOne system and received our submitter number. You will need this number when you register in ProviderOne to ensure DSHS knows your plan for us to submit and/or receive transactions on your behalf. You may access the user guide for ProviderOne at http://www.hca.wa.gov/medicaid/billing/Pages/bi.aspx ProviderOne Name: Emdeon Business Services Inc dba Change Healthcare Dental ProviderOne Submitter ID: 1054092
SEND ENROLLMENT FORMS TO:	Electronic Dental Services E-mail: Enrollment@edsedi.com or Fax: 651-389-9152
ENROLLMENT CONFIRMATION	EDS will process claims through electronically once enrollment has been completed.
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	ProviderOne Helpdesk 800-562-3022 Opt 2, then 4 Electronic Dental Services 800-482-3518

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Print/Type the following:
Insurance Carrier: **Washington State Medicaid (DHSH) - payer ID CKWA1**

Provider/Organization Name: _____

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

Software Vendor: _____

Group NPI: _____
(if applicable)

Rendering Name	NPI
_____	_____
_____	_____
_____	_____
_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

I have registered the above information within the ProviderOne system denoting Change Healthcare Dental, submitter ID 1054092, as my clearinghouse for batch claim transactions/reports.

Signature: _____ SIGN HERE

Date: _____