



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

**NEVADA MEDICAID
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

PAYER ID NUMBER	CKNV1
ELECTRONIC REGISTRATIONS Agreements Required	<p>Electronic Dental Services Provider Enrollment Form</p> <ul style="list-style-type: none"> Please complete all requested information. <p>SERVICE CENTER AUTHORIZATION FORM FOR PROVIDERS</p> <ul style="list-style-type: none"> Please fill in the Provider Name, Provider phone, Provider ID, Group ID (if applicable), Tax ID or SSN, Original Provider Signature and date.
SPECIAL NOTES	Please call FSHC provider enrollment department at 877-638-3472 for your provider number.
SEND REGISTRATION FORMS TO:	Electronic Dental Services 1304 Vermillion St Hastings, MN 55033 Attn: Provider Enrollment
ENROLLMENT CONFIRMATION	Enrollment will be coordinated between Electronic Dental Services and FHSC. Once approval is received EDS will notify the provider or their software vendor.
CHANGING ELECTRONIC BILLING AGENTS	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.
CONTACT PHONE NUMBERS	First Health Services Corporation 877-638-3472 Electronic Dental Services 800-482-3518



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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: Nevada Medicaid – payer ID CKNV1

Provider/Organization Name: _____

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

Software Vendor: EDS_____

Group Number: _____
(if applicable)

Group NPI: _____
(if applicable)

Name	Number	Rendering	NPI
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: Terri_____

Telephone Number: 651-480-8090_____ Fax Number: _____

Date: _____

Service Center Authorization

Purpose: To authorize or terminate electronic transactions through a Service Center. A Service Center may be a clearinghouse or a provider business (direct submitter). Electronic transactions are processed only if authorized by the provider by use of this form. For Pharmacy transactions, contact the Technical Call Center at (800) 884-3238.

 ~~Mail this form to First Health Services, EDI Coordinator, PO Box 30042, Reno, NV 89520-3042.~~

SERVICE CENTER SOURCE: Check one. Enter the business or clearinghouse name as appropriate.	
<input type="checkbox"/> I will submit claims through a clearinghouse. Clearinghouse Name: CPS / WebMD Dental	FIRST HEALTH SERVICES USE ONLY SC Code: 5147
<input type="checkbox"/> I will submit claims directly from my business to First Health Services (direct submitter).	
Business Name:	
AUTHORIZE A TRANSACTION: Check the box next to each transaction you wish to authorize.	
<i>I hereby authorize the Service Center named above to submit transactions on behalf of the provider until the provider notifies First Health Services otherwise by use of this form.</i>	
<input type="checkbox"/> Eligibility Request/Response (270/271) <input type="checkbox"/> Prior Authorization Request/Response (278/278) <input type="checkbox"/> Claims Status Request/Response (276/277) <input type="checkbox"/> Electronic Remittance Advice (835)*	<input type="checkbox"/> Professional claim (CMS-1500 claim: 837P) <input type="checkbox"/> Institutional claim (UB claim: 837I) <input type="checkbox"/> Dental claim (Dental Claim: 837D)
* Paper remittance advices will cease 30 days after electronic remittance advices begin. Although multiple Service Centers may submit claims for one provider, only one Service Center can receive the electronic remittance advice.	
TERMINATE A TRANSACTION: Check the box next to each transaction you wish to terminate.	
<i>I no longer authorize the Service Center named above to submit transactions on behalf of the provider unless the provider notifies First Health Services otherwise by use of this form. (Enter the effective date below.)</i>	
<input type="checkbox"/> Eligibility Request/Response (270/271)	<input type="checkbox"/> Professional claim (CMS-1500 claim: 837P)
<input type="checkbox"/> Prior Authorization Request/Response (278/278)	<input type="checkbox"/> Institutional claim (UB claim: 837I)
<input type="checkbox"/> Claims Status Request/Response (276/277)	<input type="checkbox"/> Dental claim (Dental Claim: 837D)
<input type="checkbox"/> Electronic Remittance Advice (835)	
Effective date for termination of this transaction(s):	

I understand that I am responsible for the information presented on claims that are submitted through the Service Center designated above and that all information presented on this authorization form is true, accurate, and complete. I further understand that payment and satisfaction of Nevada Medicaid and Nevada Check Up claims will be from federal and state funds and that false claims, statements, documents or concealment of material facts may be prosecuted under applicable federal and state laws.

Provider/Entity Name: _____ Phone: _____

NPI/API (one per form): _____

Federal Tax ID Number (or SSN): _____

Will you be submitting claims that have more than one payer (COB/TPL claims)? Yes No

Authorized Signature: _____ Date: _____ / _____ / _____

