Massachusetts Health Program

Attention Providers:

In order to start receiving your ERAs for Massachusetts Health Program through EDS, you will need to print and review the enrollment form. Please sign the form and submit to EDS.

Payer:	Massachusetts Health Program
Payer ID:	CKMA1
For Enrollment Questions:	Contact the EDS Enrollment Department at (800) 482 -3518 or Enrollment@edsedi.com
Enrollment Application:	**Dentaquest Electronic Remittance Advice (ERA) Authorization Agreement**
Upload, Email or Fax Application to:	Enrollment@edsedi.com Fax (800) 389-9152
Approval Process and Timeframes:	Payer estimates 30 business days for processing. EDS will deliver ERAs directly to the EDS Portal upon receipt.

DentaQuest Electronic Remittance Advice (ERA) Authorization Agreement.

Please be sure to complete all of the required fields (marked with a star) and email the completed form to EDITeam@greatdentalplans.com .

Please enter the following information:

Provider/Organization/Practice Identification:

Provider Name:* _____

Doing Business As Name (DBA): _____

Street: * _____

City:* _____

Zip Code: * _____

Country:*_____

State:* _____

Provider Identifiers:

Provider Federal Tax Identification Number (TIN):* _____

National Provider Identifier (NPI): * _____

Organization/Practice Contact Person:

Provider Contact Name: * _____

Telephone Number: * _____

Email Address: * _____

Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier)

Please choose aggregation type based on the identification used by your receiving bank on your bank account. If you are identified on your bank account by TIN, please choose TIN. If by NPI, please choose

NPI. If you are identified by TIN, please do ***not*** choose NPI. The aggregation type must match your banking institution's identification on your bank account.

☐ Provider Tax Identification (TIN) ☐ National Provider Identifier (NPI)

Method of Retrieval: *

☐Trading Partner Web Portal ☐FTP ☐Agent ☐Direct ☒Clearinghouse

Please enter information if you receive EDI transactions through a clearinghouse rather than directly.

Clearinghouse Name: * DentalXChange EDI Healthgroup Inc.

Clearinghouse Contact Name: * Enrollment

Telephone Number: * 800-576-6412 ext. 461

Email Address: * enrollment@dentalxchange.com

Reason for Submission: * ☐ New Enrollment ☐Change Enrollment ☐Cancel Enrollment

Please type your name, date, and the requested effective ERA date for this enrollment below:

Written Signature of Person Submitting Enrollment: _____

Printed Name of Person Submitting Enrollment: _____

Submission Date: _____

Requested ERA Effective Date: _____

For assistance or questions regarding this form please contact our EDI Team at EDITeam@greatdentalplans.com and a representative will contact you. You may return this form via email at EDITeam@greatdentalplans.com .