400 Vermillion Street ● Hastings, MN 55033
Ph 800-482-3518 ● Fax 651-389-9152

DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

PAYER ID NUMBER	**94267**
ELECTRONIC REGISTRATIONS Agreements Required	**Change Healthcare Provider Enrollment Form** • Please complete all requested information.
SEND REGISTRATION FORMS TO	Email to: enrollment@edsedi.com.com Or Fax: 651-369-9152
ENROLLMENT CONFIRMATION	EDS will notify the provider when registration is complete.
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently submits claims through another Billing Agent other than Change Healthcare Dental each Provider must re-enroll following the procedures listed above.
CONTACT	**Electronic Dental Services** **enrollment@edsedi.com**

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PROVIDER ENROLLMENT FORM

Insurance Carrier: **HealthPartners MN - payer ID 94267**

Print/Type the following:

Provider/Organization Legal Name:_____

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

Software Vendor: _____

Billing NPI: _____

Billing Address: _____

Billing City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Email: _____

Date: _____