eSolutions
Strengthen your revenue health
EDI Insight

Payer ID: 84367

Braven Health

835 ERA

EDI Enrollment Instructions:

- The billing provider must have an EDIinsight customer account.
- SAVE this document to your computer.
- OPEN the file in the Adobe Reader program and type directly onto the form.
- COMPLETE the form using the provider's billing/group information as credentialed with payer.
- PRINT, SIGN and SCAN or SAVE the signed form to your PC so that you may submit the form to the EDIinsight Enrollment Team using EDIinsight Enrollment Manager.
- ERA enrollment processing timeframe is approximately 30 days.
- Support Vendors may contact the EDIinsight Enrollment Team to follow up on the EDI request.
- To check status of EDI enrollment or for assistance with the completing the online enrollment, email the payer at **BravenEDI@BravenHealth.com**

835 Electronic Remittance Advice:

Electronic Remittance Advice (835) Enrollment Form (2 Pages)

- COMPLETE AND SIGN the form using the provider's billing/group information as credentialed with the payer.

Submit to EDIinsight Enrollment Team:

Within EDIinsight - Enrollment Manager:
SELECT record, CLICK **[ATTACH File]** to attach the completed payer form.
IF prompted, asking if you want to Submit the request, CLICK **[Yes]**
-Or- CLICK **[SUBMIT Enrollment]**
ENTER any notes (optional), then CLICK to **SAVE**.

Reset

Braven HEALTH

BRAVEN HEALTH
Electronic Remittance Advice (835) Enrollment

To participate in the Braven[SM] Health Electronic Remittance Advice (ERA/835) program, please email this completed form to BravenEDI@BravenHealth.com or fax this completed form to **1-973-522-4665**.

If you are using a Trading Partner to perform ERA/835, that Trading Partner **MUST BE** an authorized Braven Health ERA Trading Partner. To obtain a list of authorized Trading Partners, please email a request to BravenEDI@BravenHealth.com.

The Braven Health Payer ID is **84367.**

Provider Information Section

Provider Name: ______________________________

Provider Street Address: ______________________________

City: ______________ State/Province: ______________ ZIP Code/Postal: ______________

Provider Identifiers Information

Six-Digit UPIN: ______________ NPI: ______________

Tax Identification Numbers (TIN): ______________________________
Include all TIN suffixes as appropriate

Provider Contact Information Section

Provider Contact Name: ______________________________

Telephone: ______________ Email: ______________

Electronic Remittance Advice Information

Aggregation of Remittance Data:

TIN: ______________ NPI: ______________

Method of Retrieval (*The method by which the provider will receive the ERA from the health plan)*

☐ Download from health plan website

☒ Clearinghouse/Vendor

☐ Other ______________________________

835B (0820)

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Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name: Waystar

Clearinghouse Contact Name: Enrollment Representative

Telephone: 877-494-7633 Email: enrollment@waystar.com

Electronic Remittance Advice Vendor Information

Vendor Name: ______

Vendor Contact Name: ______

Telephone: ______ Email: ______

Submission Information

Reason for Submission (select one from below)

- ☐ New Enrollment
- ☐ Change Enrollment
- ☐ Cancel Enrollment

Authorized Signature

Name: ______

Title: ______

Signature: ______

Date: ______