

CareOregon 835

EDI Enrollment Instructions:

- The billing provider must have an **EDInsight customer account**.
- **Submit** this payer enrollment request **within EDInsight-Enrollment Manager tool**.
- Please 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 this payer.
- Once completed, save for your records, print and obtain appropriate signature(s).
- ERA setups are completed in approximately **15 business days**.
- To check status of EDI enrollment, please contact CareOregon at **800-224-4840**.

837 Claim Transactions:

EDI enrollment applies to ERA only and is not necessary prior to sending claims.

835 Electronic Remittance Advice:

CareOregon 835 Request Form

Complete the form as appropriate.

Submit Completed Document to:

Log into EDInsight-Enrollment Manager

Add or Select payer enrollment record.

Click [Attach File] to attach the document to the payer enrollment record.

Answer "Yes" to Submit the enrollment request.

Or, click [**SUBMIT Enrollment**] to submit.



CareOregon 835 Request Form

Provider Information

Provider Billing Name	Provider Tax ID Number (TIN)
Billing Address	NPI
City State Zip	Check # <small>*Any check number previously issued by CareOregon</small>

Clearinghouse Information – CareOregon EDI Payer ID 93975

I authorize CareOregon to work directly with the following clearinghouse for retrieval of our 835 files

Yes No

Name of Clearinghouse	Contact Name
Email Address	Phone
Trading Partner ID	

*Also referred to as a submitter id used in order to exchange electronic transactions.

Please Note: it is the provider's responsibility to notify CareOregon if they no longer want us to share files directly with the clearinghouse

Contact Information/Authorized Signature (835 recipient)

Last Name, First Name	Phone Number
Company/Title	Fax Number
E-mail Address(es) for all persons that should be included in e-mail notifications: 1) 2) 3)	
Authorized Signature: Print Name	Date:

Internal Use (CareOregon) to be completed by the NRA

QNXT Provider ID:	QNXT Provider Name:
Provider Relations Specialist Name:	
Date Submitted to IS:	IS - Date Completed:

Fax form to: (503) 416-1437