

---

## Central California Alliance for Health 837

### EDI Enrollment Instructions:

- The billing provider must have an EDIinsight customer account.
- **Note:** Prior to setting up Electronic Data Interchange (EDI) claims submission with the Alliance, a minimum of one paper claim must have been submitted to the Alliance so that a record for the office can be configured in Alliance systems.
- 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 15 days.
- Support Vendors may contact the EDIinsight Enrollment Team to follow up on the ERA setup request. Or, the provider may email the payer at [edisupport@ccah-alliance.org](mailto:edisupport@ccah-alliance.org) .

### 837 EDI Claims' Enrollment

CCAH EDI Claims Enrollment Form (1 page)

Complete this form using the billing provider's group information.

SEE Provider Information ENTER Contact Name, Phone No and Email Address

SEE Submission Information PUT check for New Enrollent or Change Enrollment

SEE Transmissionformation PUT check for Professional 837 and/or Institutional 837

### Submit to EDIinsight Enrollment Team:

Within EDIinsight - Enrollment Manager:

GO TO or **[ADD Payer Enrollment]** record for this payer.

SELECT record, CLICK **[ATTACH File]** to attach all pages of the completed payer form(s).

IF prompted, asking if you want to Submit the request, CLICK **[Yes]** -Or- CLICK **[SUBMIT Enrollment]**

ENTER any notes (optional)

CLICK to "**Save and Exit**" notes' window.

### NOTE: 835 Electronic Remittance Advice- ERA Enrollment

Within EDIinsight-Enrollment Manager-

Click **[ADD Payer Enrollment]**

Select "**ERA**" and continue to add a Remit enrollment record for this payer.

Click **[OPEN Enrollment Form]** to download instructions and 1-pg EchoHealth ERA Enrollment.



**EDI CLAIMS ENROLLMENT FORM**  
**IDENTIFICATION OF PROVIDER/TRADING PARTNER**  
**AND TRANSACTION INFORMATION**

All Trading Partners, whether covered entities or business associates of covered entities, agree to abide by all HIPAA Privacy and Security requirements as they apply to communications with The Alliance.

**Reminder: Prior to setting up Electronic Data Interchange (EDI) claims submission with the Alliance, a minimum of one paper claim must have been submitted to the Alliance so that a record for the office can be configured in Alliance systems.**

**PROVIDER INFORMATION (All fields required)**

Provider Name		Provider Federal Tax Identification Number (TIN)	
Doing Business As Name (DBA)		National Provider Identifier (NPI)	
Provider Address – Street	City	State/Province	ZIP Code/Postal Code
Provider Contact Name	Telephone Number (     )	Email Address	

**CLEARINGHOUSE INFORMATION (Required field)**

Are you planning to use a clearinghouse for electronic transmissions with the Alliance?	Clearinghouse Name
---	--------------------

**SUBMISSION INFORMATION (Required field)**

Reason for Submission:       New Enrollment       Change Enrollment       Cancel Enrollment

**TRANSMISSION INFORMATION (Select appropriate fields)**

<input type="checkbox"/> <b>Professional (837P)</b> (ASC X12N 005010X222)	<input type="checkbox"/> <b>Institutional (837I)</b> (ASC X12N 005010X0223)
--	--

**AUTHORIZED SIGNATURE (Person submitting form)**

Name	Signature	Submission Date and Time
------	-----------	--------------------------

Please EMAIL completed form to  
**edisupport@ccah-alliance.org**  
Or FAX to (831) 430-5895, ATTN: EDI Analyst

January 2021

To enroll in Electronic Remittance Advice (ERA), complete the following enrollment form: <https://enrollments.echohealthinc.com/EFTERALnitation.aspx?ReturnUrl=%2f> or call ECHO Technical Support at (888) 834-3511.