Community Health Group of San Diego

835

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 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 payer.
- There is a separate process for new and existing enrollments. See the directions below.
- EDI enrollment processing timeframe is approximately 5 days.
- Support Vendors may contact the EDIinsight Enrollment Team to follow up on the ERA setup request.

835-ERA Electronic Remittance Advice Enrollment:

Step 1- SUBMIT record for NEW request -Or- Complete and Email 1-page form for CHANGE request.

FOR NEW- GO TO Step 2 to submit the enrollment record.

FOR CHANGE- SEE form on next page to complete and email to the payer.

Community Health Group Electronic Remittance Advice Change Request Form (1 page)
Complete the Change Enrollment section by checking the appropriate box for your previous clearinghouse. Email the completed form to **CHGEDI@chgsd.com**.
NOTE: This payer requires the form to be sent directly to them from the providerâ€™s office. It cannot be sent from a third party.

Step 2- SUBMIT the Enrollment record to the PI Enrollment Team:

LOG INTO EDIinsight, GO TO-**[Enrollment Manager]**
LOCATE and SELECT the payer enrollment record.
CLICK **[SUBMIT Enrollment]**
ENTER note- "Please Process NEW Enrollment"
Or- "Please Process CHANGE Enrollment. Payer form has been emailed to the payer.
CLICK to "Save".
This action will advance the status of the enrollment record to PENDING.
The PI Enrollment Team will complete the enrollment.

Community Health Group

2420 Fenton Street, Suite 100 | Chula Vista, CA 91914 | (619)422-0422

Electronic Remittance Advice Change Request From

Please complete the following information and submit to CHGEDI@chgsd.com

SUBMISSION INFORMATION

Reason for Submission (please chose one)

☑ Change Enrollment Cancel Enrollment Submission Date:

PROVIDER INFORMATION

Provider Name: _____

Street Name: _____

City: _____ State: _____ Zip Code: _____

NPI: _____ Tax Id: _____

CHANGE ENROLLMENT

Select the ***current*** option provider is receiving electronic remittance advice.

☐ Change Healthcare (formerly Relay Health) ☐ Claimremedi ☐ Office Ally
☐ Trizetto(GatewayEDI) ☐ Zirmed Zotec ☐ Directly from CHG

Select the ***new*** option for provider to receive electronic remittance advice.

Change Healthcare (formerly Relay Health) Claimremedi Office Ally
Trizetto(GatewayEDI) ☑ Zirmed Zotec Directly from CHG (please contact CHGEDI@chgsd.com) other: _____

By submitting this form, provider authorizes to receive Electronic Remittance Advice for Community Health Group Claims.

COMMUNITY HEALTH GROUP USE ONLY

Approval Date: _____

Approved By: _____