

<b>Commercial Payer Claims and ERAs</b>	<p align="center"> <b>EL PASO FIRST HEALTHPLANS, INC</b>  <b>EI Paso Health- Star (EPF02) Preferred Administrators TPA (EPF10)</b>  <b>EI Paso Health CHIP (EPF03) Preferred Administrators TPA (EPF11)</b>  <b>EI Paso Health Advantage Dual SNP (EPF07)</b>  <b>EPCCS- HealthCare Options (EPF37)</b>  <b>Enrollment Instructions – Claims and ERAs</b> </p>
<b>Payer Info</b>	This payer notifies the provider when EDI/ERA is setup.      ✓ Yes      No
<b>Checklist of Requirements</b>	✓ The billing provider must have an EDInsight customer account.
<b>How and Where to Submit this Request</b>	<p> <b>Submit to EDInsight Enrollment Team:</b>          Within EDInsight - Enrollment Manager:          GO TO or <b>[ADD Payer Enrollment]</b> record for this payer.          SELECT record, CLICK <b>[ATTACH File]</b> to attach all pages of the completed payer form(s).          IF prompted, asking if you want to Submit the request, CLICK <b>[Yes]</b> -Or- CLICK <b>[SUBMIT Enrollment]</b> ENTER any notes (optional)          CLICK to "Save and Exit" notes window.       </p>
<b>Steps / Instructions for completing request</b>	<p> <b>Claims-837      FIRST-TIME EDI SETUP ONLY. OK TO SKIP THIS FORM IF THE PROVIDER WAS PREVIOUSLY SETUP AND HAS BEEN SUBMITTING ELECTRONIC CLAIMS TO THIS PAYER.</b> </p> <p> <b>1- EI Paso Health Electronic Data Interchange Request Form (1 pg)</b>          ENTER the billing provider's group information.          INCLUDE COPY of Billing Provider's W-9 Form.          SEE bottom of form. Put check next to each Product Line for which the provider intends to send electronic claims and receive electronic remits.       </p> <p> <b>ERAs-835      FIRST-TIME ERA SETUP or CHANGE ERA SETUP</b> </p> <p> <b>2- EI Paso Health Electronic Remittance Advice (835) Request Form</b>           ENTER the billing provider's group information to this form.          SEE "Confirmation of Test File" ENTER Contact Name, Phone and Email for person who can confirm receipt of the 1st Test ERA file.       </p>
<b>Estimated Time of Completion</b>	<p align="center"> <b>Allow 2-4 Weeks for the Payer to Complete this Request</b> </p>
<b>Contact Info to Follow Up or Make Inquiries</b>	The provider can contact EI Paso Health Plan at 915-532-3778 ext 1507 to make inquiries or to follow up on the enrollment request, once submitted. Support Vendors may contact the PI Enrollment Team to assist in follow up, 45 days after the request has been submitted.

El Paso First Health Plans, Inc. offers Electronic Data Interchange Interchange. Please indicate the specific EDI transaction set up requests.

- 270/271 Eligibility coverage or benefit inquiry/response
- 276/277 Claim status request/response
- 835 Remit Payment Advice (RAs)
- 837 Professional Institutional Claims

**Please fill out form and fax to Provider Relations**  
**915-532-2877 or 915-225-6762**  
 Questions/Concerns call 915-532-3778 x1507

**BILLING PAY TO PROVIDER INFORMATION (PLEASE INCLUDE W9)**

	<input type="checkbox"/> Individual Provider	<input type="checkbox"/> Group/Practice	<input type="checkbox"/> Facility
Official Business Name:			
Doing Business As:			
Billing Address:			
City, State, Zip:			
Federal Tax ID:			
Contacts:		Phone:	
Email:			

**PROVIDER INFORMATION**

Provider/Group Specialty:	
Primary Service Location:	Group NPI #:
Address:	
City, State, Zip:	
Phone: ( )	FAX:
Secondary Service Location:	
Address:	
City, State, Zip:	
Phone: ( )	FAX: ( )
Third Service Location:	
Address:	
Phone: ( )	FAX: ( )
City, State, Zip:	

Provider Name: (Last, First, Title)	Taxonomy No.	NPI#

**CLEARINGHOUSE INFORMATION (Clearing House Customer ID# through AVAILITY):**

Clearinghouse:	Practice Insight via Availity	Phone: (800) 282-4548
Billing Submitter No.	SubH4895 GENKEY 13797	
Software Vendor Name:	Practice Insight, LLC	Phone: (713) 333-6000 Opt 2
ANSI 5010:	<input checked="" type="checkbox"/> Professional <input type="checkbox"/> Institutional	
Clearinghouse Name:	Availity	

**Authorization Statement Signature**

Provider (enter provider/designated representative name) \_\_\_\_\_ hereby appoints (enter vendor name) Practice Insight \_\_\_\_\_ to act as the authorized agent for the purpose of retrieving the 835 electronically from El Paso First Health Plans, Inc.

**Provider/Provider Representative Signature: \_\_\_\_\_ DATE \_\_\_\_\_**

**Please check the Product Line you plan to send/receive EDI transaction files.**

<input type="checkbox"/> Medicaid- El Paso First Premier Plan (STAR)	Availity PAYER ID# EPF02
<input type="checkbox"/> CHIP – El Paso First	Availity PAYER ID# EPF03
<input type="checkbox"/> CHIP Perinate	Availity PAYER ID# EPF03
<input type="checkbox"/> EPCCS – Health Care Options – Benefit Plan	Availity PAYER ID# EPF37
<input type="checkbox"/> Preferred Administrators (TPA) – UMC	Availity PAYER ID# EPF10
<input type="checkbox"/> Preferred Administrators (TPA) – El Paso Childrens Hospital	Availity PAYER ID# EPF11



### BILLING PAY TO PROVIDER INFORMATION (PLEASE INCLUDE W9)

Official Business Name: \_\_\_\_\_

Doing Business As: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Federal Tax ID: \_\_\_\_\_ Group NPI: \_\_\_\_\_

Primary Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### PROVIDER INFORMATION

Primary Service Location: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Website URL: \_\_\_\_\_

### CLEARINGHOUSE INFORMATION

Clearinghouse Name: **Practice Insight via Availity** Phone: **800-282-4548**

\*Availity Customer ID# (**Genkey**): **13797** Billing Submitter Number: **13797**

Software Vendor Name: **Practice Insight** Phone: **713-333-6000 Opt 2**

**\*Genkey is required for Availity.**

### AUTHORIZATION STATEMENT SIGNATURE

Provider (enter provider/provider representative name) \_\_\_\_\_ hereby appoints (enter vendor name) **Practice Insight/Availity** to act as the authorized agent for the purpose of retrieving the 835 electronically from El Paso Health.

Provider/Provider Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### EL PASO HEALTH PAYER IDs

El Paso First Health Plans Premier Plan STAR Medicaid HMO Availity/ Trizetto Provider Solutions Payer ID: EPF02

El Paso First Health Plans CHIP Availity/ Trizetto Provider Solutions Payer ID: EPF03

El Paso First Health Plan HCO Healthcare Options Availity/ Trizetto Provider Solutions Payer ID: EPF37

Preferred Administrators Availity/ Trizetto Provider Solutions Payer ID: EPF10

Preferred Administrators Children's Hospital Availity/ Trizetto Provider Solutions Payer ID: EPF11

### CONFIRMATION OF TEST FILE

After submission of the Electronic Remittance Advice Request Form, a test file will be sent to ensure the successful transmission of the 835 file. Please enter the contact information for the representative that will be able to confirm receipt of the test file. Please note that the test file must be confirmed before the process can be completed. Failure to confirm the test file within 30 calendar days will cause the request to be closed and a new request will need to be submitted.

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_