Practice Insight®

Rev Date 01/09/2019
Rev Type (IE,NF)

Commercial Payer	**Health Care District Palm Beach County (HCDPB)** **Enrollment Instructions – Professional Claims (837)**
Payer Info	This payer allows the provider to be linked to more than one clearinghouse for submission of electronic claims. ✓ **Yes** **No** This payer sends confirmation when EDI enrollment is approved. ✓ **Yes** **No**
Checklist of Requirements	✓ The billing provider must have a Practice Insight EDI customer account number with billing provider Name, Tax ID and NPI. ✓ Copy of HCFA 1500 form needed.
How and Where to Submit this Request	**SUBMIT To- Practice Insight** LOG INTO EDIinsight® GO TO **[Search Tools]** → **[Enrollment]** ADD or LOCATE, then SELECT payer enrollment record. CLICK **[ATTACH File]** to attach completed form to the record. CLICK **[SUBMIT Enrollment to PI]** to assign to Practice Insight for processing.
Steps / Instructions for completing request.	**1. EDI Enrollment Request for New Submitter (3 pages)** **Section I. Organization Information** ENTER the billing provider's group information. **Section III. (Box 33 of Paper claim)** ENTER NPI in the box that is correct for this billing provider. REVIEW a HCFA 1500 paper claim for data in box 24j, 32a, or 33a. **2. Include a copy of the HCFA 1500 form.**
Estimated Time of Completion	**Allow 4 Weeks for ERA setup to be completed by the payer.**
Contact Info to Follow Up or Make Inquiries	*Contact your EDI support vendor for assistance. Practice Insight Resellers or Support Vendors may contact Practice Insight Enrollment Department to check on status of enrollment after 45 days.*

EDI Enrollment Request for New Submitter

(Please Print Legibly)

Section I. Organization Information

Practice/Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Telephone : _____

Email: _____

Section II. Clearinghouse

Clearinghouse Name: Availity LLC

Contact Name: Client Support Telephone: 800-282-4548

Email aacenrollment@availity.com Fax: 972-383-6415

Requested Claim Transactions: 837 PROF

Section III: (Box 33 of Paper Claim)

Payee Name: _____

Address: _____

City: _____ State: _____ Zip: _____

TIN Number: _____

Contact Name: _____ Telephone: _____

Email: _____

Sole Practitioners
Individual NPI Number: (24j) _____

Service Location
NPI Number: (32a) _____

Ancillary/Group Providers: _____
Organizational NPI Number: (33a)

To complete the application, please submit a copy of your HCFA 1500 and include pages 12 and 13.
Page 12 must be signed and dated.

The undersigned hereby:

- Authorizes Health Care District of Palm Beach County and Healthy Palm Beaches to disclose protected health information to the business associate identified in Section II;

- Agrees to notify Health Care District of Palm Beach County and Healthy Palm Beaches of any changes in NPI, provider, address or change in Medicaid registration information as identified in this agreement.

The user of this form agrees to:

1) Use sufficient security procedures to ensure that all transmission of documents are authorized and protect all subscriber-specific data from improper access;

2) Submit transactions that are HIPAA compliant in both formatting and coding standards; and

3) Establish and maintain procedures and controls so that information concerning Health Care District of Palm Beach County and Healthy Palm Beaches subscribers, or any information obtained from Health Care District of Palm Beach County or Healthy Palm Beaches shall not be used by agents, officers, or employees of the billing services except as provided by Health Care District of Palm Beach County and Healthy Palm Beaches.

_____ ___ ___ ___

Authorized Signature Date

PLEASE BE SURE THAT ALL INFORMATION IS COMPLETE, TRUE, AND ACCURATE.

PLEASE FAX TO BUSINESS ANALYTICS AT (561) 802-3972 OR EMAIL FORMS TO

BUSINESSANALYTICS@HCDPBC.ORG.

NOTIFICATION WILL BE SENT THAT YOU ARE READY TO SUBMIT EDI CLAIMS.

DO NOT SUBMIT CLAIMS UNTIL YOU ARE NOTIFIED THAT SET-UP IS COMPLETE.

EDI Enrollment Request Additional Participating Provider(s) Individual Information

Please provide the following individual information exactly how you have registered with the State.

Please fax to Business Analytics at 561-802-3972

Name: ______________________ **Medical License Number:** ______________________
NPI: ______________________ **Specialty:** ______________________
Medicaid # (If applicable) ______________________ **Taxonomy (If applicable)** ______________________
Tax ID # ______________________ **Zip Plus 4 (If applicable)** ______________________
Payment Address (If different from application)

Name: ______________________ **Medical License Number:** ______________________
NPI: ______________________ **Specialty:** ______________________
Medicaid # (If applicable) ______________________ **Taxonomy (If applicable)** ______________________
Tax ID # ______________________ **Zip Plus 4 (If applicable)** ______________________
Payment Address (If different from application)

Name: ______________________ **Medical License Number:** ______________________
NPI: ______________________ **Specialty:** ______________________
Medicaid # (If applicable) ______________________ **Taxonomy (If applicable)** ______________________
Tax ID # ______________________ **Zip Plus 4 (If applicable)** ______________________
Payment Address (If different from application)

Name: ______________________ **Medical License Number:** ______________________
NPI: ______________________ **Specialty:** ______________________
Medicaid # (If applicable) ______________________ **Taxonomy (If applicable)** ______________________
Tax ID # ______________________ **Zip Plus 4 (If applicable)** ______________________
Payment Address (If different from application)
