

Health Plan of Upper Ohio Valley

835

EDI Enrollment Instructions:

- The billing provider must have an EDInsight 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 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 EDInsight Enrollment Team using EDInsight Enrollment Manager.
- ERA enrollment processing timeframe is approximately 14 days.
- Support Vendors may contact the EDInsight Enrollment Team to follow up on the ERA setup request.

835 Electronic Remittance Advice:

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

1. The Health Plan Electronic Data Interchange (EDI) Enrollment Form (1 page)

Check the corresponding box under 'Enrollment Type.'

Complete the 'Administrator Information' section.

Provider or Authorized Individual must print name, title, email, date and sign under the 'Authorized Signature' section.

2. Provider Information Form (1 page)

Complete the 'Provider Contact Information' section.

Check your 'Reason for Submission.'

Provider or Authorized Individual must print name, title, and initial under the 'Authorized Signature' section.

Submit to EDInsight Enrollment Team:

Within EDInsight - 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.



Electronic Data Interchange (EDI) Enrollment Form

To enroll with The Health Plan (THP) EDI transactions, please complete and return this form to your EDI clearinghouse.

THP Submitter ID: 95677
Dental Only: 34150

Date	
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Enrollment Type	
<input type="checkbox"/>	Initial Enrollment
<input type="checkbox"/>	Update Existing Enrollment
<input type="checkbox"/>	Term Existing Enrollment

Provider Information

Entity Legal Name:					
Address:		Group NPI:		TIN:	
City:		State:		Zip:	

EDI Enrollment Information

<input checked="" type="checkbox"/>	Transaction Type	Description	Trading Partner	Provider's Clearinghouse
<input type="checkbox"/>	837 P	Healthcare Claim: Professional	Optum iEDI	
<input type="checkbox"/>	837 I	Healthcare Claim: Institutional	Optum iEDI	
<input type="checkbox"/>	837 D	Healthcare Claim: Dental	Optum iEDI	
<input checked="" type="checkbox"/>	835	Electronic Remittance Advice (ERA)	Optum iEDI	
<input type="checkbox"/>	270	Eligibility or Benefit Information	Optum iEDI	
<input type="checkbox"/>	276	Claim Status Request	Optum iEDI	
<input type="checkbox"/>	278	Authorization/Referral Request & Response	Optum iEDI	

Administrator Information

All correspondence will be sent by email to the Account Administrator.

Administrator's Name:	
Administrator's Title:	
Administrator's Phone Number:	
Administrator's Email:	

Authorized Signature

Authorized Signature's Name:			
Authorized Signature's Title:			
Authorized Signature's Email:			
Authorized Signature:		Date:	

Provider Information

Provider Name: _____
Doing Business As Name (DBA): _____

Provider Address

Street: _____
City: _____ State/Province: _____ Zip Code/Postal Code: _____
Country Code: _____

Provider Identifiers

Provider Federal Tax Identification Number (TIN)
or Employer Identification Number (EIN): _____
National Provider Identifier (NPI): _____

Provider Contact Information

Contact: _____ Title: _____
Telephone Number: _____ Telephone Number Extension: _____
Email Address: _____
Fax Number: _____

Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data
Provider Tax Identification Number (TIN): ____
Nation Provider Identifier (NPI): ____

Submission Information

Reason for Submission: New Enrollment Change Enrollment
 Cancel Enrollment

Authorized Signature

Electronic Signature of Person Submitting Enrollment: _____ (Insert Initials to Sign Agreement)
Printed Name of Person Submitting Enrollment: _____
Printed Title of Person Submitting Enrollment: _____