

## Independent Health 837 and 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 the provider's billing/group information as credentialed with this payer.
- EDI enrollment processing timeframe is approximately 10 business days.
- To check status of EDI enrollment, please email [e-commerce@independenthealth.com](mailto:e-commerce@independenthealth.com) and make sure the Tax ID is included in the email.

### 837 Claim Transactions and 835 Electronic Remittance Advice:

#### 1. Fax NPES Confirmation Document to IHEALTH at 716-635-3763

To request a replacement NPI confirmation document, contact the Enumerator Office at 1-800-465-3203. You may also request a replacement online via the following link: <https://nppes.cms.hhs.gov/NPPES/LoginPage.do?userType=PROVIDER>

#### 2. Electronic Claims Sender Request Form (1 page)

- Indicate your reason for request by checking the appropriate box.
- Indicate the transaction(s) you would like to enroll for by checking the appropriate box.
- Complete the Office Contact Information fields.

#### 3. Electronic Transaction Agent Designation Letter (1 page)

The Authorized Agent is the Billing Company or the Authorized Provider.

Billing Companies- If you have already received a Submitter ID and are adding a new provider, you only need to complete the Electronic Transaction Agent Designation Letter.

- Authorized Agent must input their name in both places indicated on the agreement.
- Authorized Agent must sign, print name, address, phone number, date and Tax ID where indicated.
- Agents with an Existing Submitter ID must input the ID where indicated.

#### 4. EDI Enrollment Form- Application for Electronic Remittance Advice 835 (ERA) (3 pages)

- Complete all applicable fields.
- Under Section 10 – Submission Information on Page 3, indicate your Reason for Submission by checking the appropriate box.
- Provider or Provider's Representative must print name, title, date, and sign where indicated on Page 3.

#### 5. Look to receive an email from Independent Health confirming edi setup with assignment of 3-char code to the billing provider to be used in submitting electronic claims. Please forward the email to [pi-enrollment@waystar.com](mailto:pi-enrollment@waystar.com) or contact your support vendor to report this 3-character code. Once received, this code must be added to your EDI customer profile (SUBIDIH entry on provider record) before the provider can begin submitting claims to this payer.

### Submit Completed Documents to EDIinsight Enrollment:

LOGON to EDIinsight-Enrollment Manager

ADD or SELECT payer enrollment record.

CLICK [**ATTACH File**] to attach the documents to the payer enrollment record. **Answer "Yes"** to Submit.

Or, click [**SUBMIT Enrollment**] to submit.



## Electronic Claims Sender Request Form

Please fax the completed form to (716) 929-1062.

Please contact the E-Commerce call center at (716) 635-3911 with any questions.

**Please indicate reason for request:**

New EDI Submitter  Software Vendor Change  Other: \_\_\_\_\_

**Please indicate the transaction(s) you would like to exchange:**

ANSI 837 Institutional  ANSI 837 Professional

Office Practice Name: \_\_\_\_\_ Date of Request: \_\_\_\_\_

Office Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Office Contact Person: \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Tax ID#: \_\_\_\_\_ NPI Number(s): \_\_\_\_\_

Multiple Offices with same Tax ID#:  Yes  No

Multiple Offices with multiple Sender Id's:  Yes  No

Will your office be using a Clearinghouse:  Yes  No

Clearinghouse Name: \_\_\_\_\_ Clearinghouse Contact: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_ Contact E-Mail Address: \_\_\_\_\_

Practice Management Software: \_\_\_\_\_ Contact Person: \_\_\_\_\_

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

Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Desired Submission Method:  Web Upload  SSL with PGP Encryption  SFTP with PGP Encryption  CORE - HTTP MIME Multipart  CORE - SOAP + WSDL

Please contact the eCommerce Call Center at (716) 635-3911 with any questions.



**Electronic Transaction Agent Designation Letter**

Independent Health Association, Inc.  
Attn: e-Commerce Dept.  
511 Farber Lakes  
Buffalo, New York 14221

Date: \_\_\_\_\_

Dear Sir or Madam:

I, \_\_\_\_\_, authorize \_\_\_\_\_ to  
Authorized Agent for Covered Entity Clearinghouse/Payment Processor  
exchange electronic files and access electronic documents, as described  
below, with Independent Health Association, Inc. for \_\_\_\_\_.  
Covered Entity

I further certify that a valid Business Associates Agreement is in effect

between: (1) the \_\_\_\_\_ and \_\_\_\_\_  
Clearinghouse/Payment Processor Covered Entity  
and its subsidiaries and (2) \_\_\_\_\_ and \_\_\_\_\_.  
Covered Entity Authorized Agent for Covered Entity

**We are requesting access to the following types of files to exchange and/or review:**

- 837 Electronic Claim Files and Response Files
- 835 Electronic Remittance Advices
- Electronic Documents on Reveal (Requires Reveal Intake Form & User Agreement)

Sincerely,

\_\_\_\_\_  
Signature of Authorized Agent for Covered Entity

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Authorized Agent for Covered Entity

\_\_\_\_\_  
Tax ID

\_\_\_\_\_  
Address

\_\_\_\_\_  
Submitter/Trading Partner ID

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number (including Area Code)

*Please fax this letter to (716) 929-1062. No information will be released to the Clearinghouse/Payment Processor until a signed letter is returned to Independent Health.*



# EDI Enrollment Form for Medical Claims

## Application for Electronic Remittance Advice 835 (ERA)

Independent Health: Electronic Remittance Advice (ERA) Authorization Agreement

\* Indicates a required field.

### Section 1 – Provider Information:

\* Provider Name:

Doing Business As Name (DBA):

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\* Provider Address:

\* Street:

\* City:  \* State/Province:  \* Zip Code/Postal Code:

Country Code:

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### Section 2 – Provider Identifiers Information:

#### Provider Identifiers

\* Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):

\* National Provider Identifier (NPI):

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#### Other Identifier(s)

\* Assigning Authority:  Trading Partner ID:

Provider License Number:  License Issuer:

Provider Type:  Provider Taxonomy Code:

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### Section 3 – Provider Contact Information:

\* Provider Contact Name:

Title:

\* Telephone Number:  Telephone Number Extension:



# EDI Enrollment Form for Medical Claims

## Application for Electronic Remittance Advice 835 (ERA)

\* Email Address:

Fax Number:

### Section 4 - Provider Agent Information:

\* Provider Agent Name:

\* Street Address:

\* City:  \* State:  \* Zip:

Contact Name:

Title:

Telephone #:  Fax #:

E-mail Address:

### Section 7 – Electronic Remittance Advice Information:

\* Must select one of the following:

* Billing NPI Number	Name of Billing Provider
<input type="text"/>	<input type="text"/>
* Billing Tax ID Number	Name of Billing Provider
<input type="text"/>	<input type="text"/>

Method of Retrieval: \* Must select one of the following:

Internet FTP       Secure FTP       Transaction Assistant

### Section 8 – Electronic Remittance Advice Clearinghouse Information

\* Clearinghouse Name:

Clearinghouse Contact Name:

Telephone Number:

Email Address:  Fax Number:



# EDI Enrollment Form for Medical Claims

## Application for Electronic Remittance Advice 835 (ERA)

### Section 9 – Electronic Remittance Advice Vendor Information:

\* Vendor Name:

Vendor Contact Name:

Telephone #:

E-mail Address:

### Section 10 – Submission Information:

- \* Reason for submission:
- New Enrollment (request for a new trading partner number)
  - Change Enrollment
  - Cancel Enrollment

\* **Authorized Signature** - A signature is required from either the provider or an authorized provider representative. Only one billing provider may be enrolled per form.

Provider or  
Provider's Representative

(Sign)

(Print)

Click here to enter a date.

(Print Title) (Date)

Completed EDI enrollment forms may be emailed to: [e-commerce@independenthealth.com](mailto:e-commerce@independenthealth.com)

Or faxed to: 716-929-1062

Or mailed to: Independent Health  
 ATTN: eCommerce  
 511 Farber Lakes Drive  
 Buffalo, NY 14221