

## MAPFRE Life Puerto Rico 837, 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 payer.
- PRINT, SIGN and SCAN or SAVE the signed form to your PC so that you may submit the form to the EDIinsight Enrollment Team using EDIinsight Enrollment Manager.
- EDI enrollment processing timeframe is approximately 10 days.
- Support Vendors may contact the EDIinsight Enrollment Team to follow up on the EDI setup request.
- The payer sets up providers for claims and remits at the same time.
- The provider must be located in Puerto Rico to be enrolled.

This payer sets up providers for claims and remits at the same time

### 837 Claims Transactions:

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

#### 1. Assertus Provider Enrollment Transmission Authorization

Complete the entire form using the Billing Provider's information.  
Complete the Postal Address fields if different from your Billing Address.  
Authorized Signature signed at bottom of form.

### Submit to EDIinsight Enrollment Team:

Within EDIinsight - 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.

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.



**PROVIDER ENROLLMENT  
TRANSMISSION AUTHORIZATION**

**By completing and signing this authorization, the healthcare Provider is authorizing Assertus Holdings, LLC to interchange its electronic Healthcare transactions with the Trading Partner acting as a Delegate Transmission Site for the Healthcare Provider as reported hereunder.**

Delegate Transmission Site		Site Account Number		NPI	
Provider Name		Phone		Fax	
Type <input type="checkbox"/> Solo Practitioner <input type="checkbox"/> Group Practice		Email			
Street Address		Postal Address <input type="checkbox"/> Same as Street Address			
<b>Notes:</b>					
<p><b>Authorization</b></p> <p>Hereby, I certify that I'm the Provider referenced above or an authorized representative and that the reported NPI on this form belongs to the Provider referenced above, and I authorize ASSERTUS Holdings, LLC for the interchange of related health care transactions thru the Delegate Transmission Site reported on this form. I understand that this authorization will remain active until canceled in writing. I also understand that it is my responsibility to monitor that every claims file submitted to Assertus has a positive confirmation receipt received and that I need to report to Assertus any missing confirmation receipts.</p>					
Billing Provider Authorized Signature		Date:	ASSERTUS Authorized Signature		Date: