
UHA University Health Alliance Hawaii (99026) Enrollment Instructions – Institutional Claims and ERA

- ✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record(s) added.** Please contact your EDI Support Vendor to confirm your EDI setup.

Submit completed documents to UHA:
Email to: hipaa-edi@uhahealth.com
or
Fax to: 877-269-5568

CLAIMS (837) NEW or CHANGE OF SERVICE

1. UHA EDI 837 INSTITUTIONAL CLAIM REGISTRATION (2 pages)

Page 1 SEE *Facility Identification Information*
ENTER GROUP Federal Tax ID and Organizational NPI
ENTER ALL of the Facility/Billing Provider information.

Page 2 OBTAIN Authorized Signature. ENTER Title and Date of Person signing.

ELECTRONIC REMITTANCE ADVICE (ERA/835) NEW or CHANGE OF SERVICE

2. UHA ERA REQUEST FORM (2 pages)

Page 1 SEE *Section I Provider Information, Section II Provider Identifiers Information ,
Section III Provider Contact Information*
ENTER the Billing Provider's Group Information.

Page 2 SEE Section IV *Electronic Remittance Advice Information*
ENTER the Billing Provider's Group TIN # and Group NPI #.

SEE *Section VI Submission Information* ENTER NEW CHANGE or CANCEL
SEE *Authorized Signature* OBTAIN signature of person authorized to sign for this group.

ALLOW 2-3 WEEKS FOR PROCESSING

*If you do not receive confirmation within 20 business days, contact your
EDIinsight Support Vendor for assistance or contact University Health Alliance at:
1-800-458-4600.*



700 Bishop Street, Suite 300
 Honolulu, HI 96813.4100
 T 808.532.4000
 800.458.4600
 F 877.269.5568
 uhahealth.com

EDI 837I INSTITUTIONAL CLAIM REGISTRATION

The information provided on this EDI registration will be used to set up your office for electronic claims submission. **Please complete this form as accurately as possible.** If a section is not applicable, write "N/A." Please notify UHA of any changes to the information you have provided below.

UHA requires that all Providers read UHA's Trading Partner Agreement which can be found at:

uhahealth.com/uploads/forms/form_edi_trading_partner_agree.pdf

By signing this form, you acknowledge that you have read the Trading Partner Agreement and agree to its terms.

Mail, Fax or Email your completed form to: **UHA**
Attention: Information Services
700 Bishop Street, Suite 300
Honolulu, HI 96813
Email: hipaa-edi@uhahealth.com
Fax: 1-877-269-5568

Facility Identification Information: Federal Tax ID / NPI: _____ / _____

Facility Information:

Name: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Physical Address: _____ City: _____ State: _____ Zip Code: _____

Contact: _____ Telephone: _____ Fax: _____

Email: _____

Clearinghouse Information:

Name: eSolutions, Inc. (fka ClaimRemedi)

Mailing Address: P O Box 25407 City: Overland Pa State: KS Zip Code: 66225

Physical Address: 8215 W. 108th Terrace City: Overland Pa State: KS Zip Code: 66210

Contact: Enrollment Department Telephone: 866-633-4726 Fax: 913-273-2455

Email: Enrollment@claimremedi.com

If you wish to receive your remittance advice (835) electronically, then please fill out and complete the ERA Request Form.

I authorize the setup and/or change noted above for the EDI 837I transaction.

Print Name

Signature

Date

Title

<p>To be completed by UHA</p> <p>Transmitter ID: _____</p> <p>Submitter ID: _____</p>
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ERA REQUEST FORM

The information provided on this form will be used to set up your office for Electronic Remittance Advice (ERA). **Please complete this form as accurately as possible.** If a section is not applicable, write "N/A."

In order to receive an Electronic Remittance Advice (ERA), you must be enrolled for electronic claims submission.

Mail, Fax or Email your completed form to: **UHA**
Attention: Information Services
700 Bishop Street, Suite 300
Honolulu, HI 96813
Email: hipaa-edi@uhahealth.com
Fax: 1-877-269-5568

I. Provider Information

Provider Name: _____
Complete legal name of institution, corporate entity, practice or individual provider

Provider Address:

Street: _____

City: _____

State/Province: _____

ZIP Code/Postal Code: _____

II. Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

National Provider Identifier (NPI) _____

III. Provider Contact Information

Provider Contact Name: Contact: _____

Telephone Number: _____

Email Address: _____

Fax Number: _____

IV. Electronic Remittance Advice Information

If you want to receive an Electronic Remittance Advice (ERA), then please complete this section.

Provider Tax Identification Number (TIN): _____

National Provider Identifier (NPI) _____

V. Electronic Remittance Advice Clearinghouse Information

If you want to receive an Electronic Remittance Advice (ERA) through your Clearinghouse, then please complete this section.

Clearinghouse Name: eSolutions, Inc. (fka ClaimRemedi)

Clearinghouse Contact Name: Enrollment Department

Telephone Number: 866-633-4726

Email Address: Enrollment@claimremedi.com

VI. Submission Information

Reason for Submission: _____

Authorized Signature: _____

Printed Name of Person Submitting Enrollment: _____