Questions? Please contact your EDI Support Vendor for help with EDI enrollment forms
12/13/2016 (NF)
https://www.uhahealth.com/

UHA University Health Alliance Hawaii (99026)
Enrollment Instructions –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.

CHOOSE ONE METHOD- to submit to Practice Insight

A. **Enrollment Manager:** PI Support Vendors can submit request using this tool.

B. **Email:** enrollment@practiceinsight.net

CLAIMS (837) NEW or CHANGE OF SERVICE

1. UHA EDI 837P PROFESSIONAL CLAIM REGISTRATION (2 pages)

Page 1 SEE ***Provider Identification Information***
ENTER GROUP Federal Tax ID and Organizational NPI
ENTER ALL of the individual Provider Names and NPI #'s billing under this group.

Page 2 SEE ***Provider Demographic Information***
ENTER Billing Provider's Group Name, Address, and Contact Information
OBTAIN Authorized Signature. ENTER Title and Date of Person signing.

ERAS (835) NEW or CHANGE OF SERVICE

2. UHA ERA REQUEST FORM (2 pages)

Page 1 SEE ***Section 1 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 2-4 WEEKS FOR PROCESSING

If you do not receive confirmation within 20 business days, contact your Practice Insight Support Vendor for assistance. Practice Insight Resellers may contact Practice Insight Enrollment Dept.

700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
T 808.532.4000
Toll-free 800.458.4600
www.uhahealth.com

EDI 837P PROFESSIONAL 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:

https://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.

Email your completed form to: **PNT Data**
Email: remits@pntdata.com

Provider Identification Information: Federal Tax ID_____ / Organization (Type2) NPI (if applicable): _____

Please list all Providers, along with their individual (Type1) NPI's that apply to the above Organization, if applicable.

Provider Name:	Individual (Type1) NPI:

For additional Providers, please attach a separate list

Provider Demographic Information:

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

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

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

Contact: _____ Telephone: _____ Fax: _____

Email: _____

Clearinghouse Information

Name: PNT Data

Mailing Address: 2080 Silas Deane Hwy Suite 302 City: Rocky HIll State: CT Zip Code: 06067

Physical Address: 2080 Silas Deane Hwy Suite 302 City: Rocky HIll State: CT Zip Code: 06067

Contact: Remittance Department Telephone: 860-257-2030 Fax: _____

Email: remits@pntdata.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 837P transaction. By typing a signature below, I agree that the signature will be the electronic representation of my signature for all purposes when I use them on on this form, just the same as a pen-and-paper signature.

_____ _____ _____
Title Signature Date

To be completed by UHA

Transmitter ID:_____

Submitter ID:_____

700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
T 808.532.4000
Toll-free 800.458.4600
www.uhahealth.com

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.

Email your completed form to: **PNT Data**
Email: **remits@pntdata.com**

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: PNT Data

Clearinghouse Contact Name: Remittance Department

Telephone Number: 860-257-2030

Email Address: remits@pntdata.com

VI. Submission Information

I authorize the setup and/or change noted above for the 835 transaction. By typing a signature below, I agree that the signature will be the electronic representation of my signature for all purposes when I use them on on this form, just the same as a pen-and-paper signature.

Reason for Submission: New Enrollment/Change/Cancel Enrollment

Authorized Signature: _____