

## Valley Health Plan 837 Professional

### EDI Enrollment Instructions:

- The billing provider must have an EDInsight customer account.
- SAVE this document to your computer. OPEN the file in Adobe Reader. TYPE directly on form pages.
- COMPLETE the form using the provider's billing/group information as credentialed with this payer.
- ONCE completed, ATTACH form to payer enrollment record within EDInsight Enrollment Manager.
- SUBMIT enrollment request to EDInsight Enrollment team, using EDInsight Enrollment Manager.
- EDI enrollment processing timeframe is approximately 20 business days.
- A W9 is required by the payer for enrollment. Please include a copy of your W9 along with the agreement.
- Support Vendors may contact EDInsight Enrollment Team to request follow up on the request.

### 837 Claims Transactions:

#### UHIN EDI Enrollment Form (1 page)

Complete the Provider Contact Information fields on Page 1.

Provider or Authorized Individual must sign under the '**Submission Information**' section on Page 1.

### Submit Completed Documents to EDInsight Enrollment:

LOGON to EDInsight-Enrollment Manager

ADD or SELECT payer enrollment record.

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

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

Provider ID:

DBQ

NPI: 1871720540

Tax ID: 270275794



**AUTO-VALIDATED**

Payer Agreement Cover Sheet

Return completed agreements to:  
Change Healthcare  
Attn: Enrollment Dept. (IADU-DC2)  
301 Data Court  
Dubuque, Iowa 52003

**Agreement Type: Claims**

Estimated Approval Time: 12

Multiple Clearinghouses: No

<input checked="" type="checkbox"/> CPID 6238	Valley Health Plan (Medi-Cal) - Professional
<input type="checkbox"/> CPID 6818	Valley Health Plan (Commercial) - Professional
<input type="checkbox"/> CPID 9647	Valley Health Plan (Commercial) - Institutional
<input type="checkbox"/> CPID 9648	Valley Health Plan (Medi-Cal) - Institutional

**Special Instructions: \*A W-9 is REQUIRED by the payer for enrollment.\***

**The physical address is required.**

CID \_\_\_\_\_

Submitter ID 923001      Customer ID 1006599      Billing ID 9230

Submitter Name ZIRMED INC

Reference ID account number

NPI 1871720540

TaxID 270275794

8E



Claims



# UHIN EDI ENROLLMENT FORM

Email this form to [Support@officeally.com](mailto:Support@officeally.com). The Email Subject should read: UHIN EDI Enrollment. Please make sure to print legibly and to complete this form in its entirety. Standard processing time is 10 business days. You risk delaying enrollment if the application is unreadable or incomplete. All fields in **bold** are **required**.

## PROVIDER INFORMATION

Provider Name:

Provider Address:  City:  State:  Zip:

## PROVIDER IDENTIFIERS INFORMATION

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

## PROVIDER CONTACT INFORMATION

Contact Name:  Telephone Number/Extension:   
Email Address:  Fax Number:

## PROVIDER PHYSICAL ADDRESS (if different from above)

Provider Address:  City:  State:  Zip:

## PAYER NAMES (CHECK ALL THAT APPLY)

- SX105 - Deseret Mutual Benefit Administrators *(Professional claims only)*
- VHP01 - Valley Health Plan (Commercial) *(Professional and Institutional claims)*
- VHP02 - Valley Health Plan (Medi-Cal) *(Professional and Institutional claims)*

## SUBMISSION INFORMATION

Authorized Signature:

Note: Electronic Signature (Typed Name) of Person Submitting EDI Enrollment.