eSolutions
Strengthen your revenue health
EDI Insight

Payer ID: 13010

Vaya Health (Smoky Mountain)

837- PROF

Refer to 837-INST form if provider submits INST claims or both PROF and INST claims.

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.

837 Claims Transactions: **Use form on next page if provider submits only PROF claims to payer.**

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

Vaya Health Connectivity Request (1 page)

Complete the Provider Contact Information fields.

Enter the estimated number of claims you submit each month to the payer.

Provider (if solo practice), Owner, President or CEO (if group practice) must date, print name, title, and sign where indicated.

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.

Vaya Health Electronic Connectivity Request

Please complete and submit the form below via email to EDI@vayahealth.com. **NOTE: Each provider contracted with Vaya Health is required to submit a separate connectivity request form, even if using the same clearinghouse.**

Provider name	National Provider ID (NPI)

Contact person	Title

Mailing address	City	State	ZIP Code

Phone number	Fax number	Email address (required)

Estimated number of claims each month: _____

Name of vendor/clearinghouse	Contact person	Title
Practice Insight	Enrollment Dept.	Enrollment Dept.

Mailing address	City	State	ZIP Code
1 Greenway Plaza, Suite 350	Houston	TX	77046

Phone number	Fax number	Email address (required)
713-333-6000 (opt 2)	713-333-0138	pi-enrollment@waystar.com

_____ **Printed name/title (required)**

_____ **Authorized signature (required)**

_____ **Date**