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**Vaya Health (Smoky Mountain)**  
**837 INST**

**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:**

**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](mailto: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	
Mailing address		City	State	ZIP Code
Phone number	Fax number	Email address (required)		

\_\_\_\_\_  
Printed name/title (required)

\_\_\_\_\_  
Authorized signature (required)

\_\_\_\_\_  
Date