eSolutions
Strengthen your revenue health
EDI Insight

Payer ID 94163

Vision Service Plan (VSP)
835

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.
- ERA enrollment processing timeframe is approximately _45___ days.
- Support Vendors may contact the EDIinsight Enrollment Team to follow up on the ERA setup request.

835 ERA Enrollment (There is no requirement for Claims' enrollment)

Complete and submit these form(s) using the billing provider's group information.

1. **Payor Agreement Cover Sheet (1 Page)**
2. **Vision Service Plan (VSP) Enrollment Form (1 Page)**

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(s).
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.

CHANGE HEALTHCARE

Payor Agreement Cover Sheet

Agreement Type:	Claims / Remittance
Estimated Approval Time:	10 days from Change Healthcare's receipt of agreement
Multiple Clearinghouses:	No

CPID: 6714 **Payor Name:** Vision Service Plan (VSP) – Professional

This form should be returned to Change Healthcare by emailing to enrollmentcentral@changehealthcare.com or by faxing to: 916-267-2963 with this coversheet as the first page.

Provider is automatically setup to receive ERA's when enrolling for claim submission.

Submitter ID 923001 **Customer ID** 1006599 **Billing ID** 9230

Submitter Name: ZirMed

Reference ID: _____

NPI: _____

Tax ID: _____

Does the Provider also want to be setup for ERA? Yes ☑ No ☐

Claims

 Last Revised 9/1/2020

Vision Service Plan (VSP)

Please supply the following provider information to request EDI Enrollment

Provider Type: ☐ **Out of Network** ☐ **Affiliate** ☐ **GAP**

Provider Group Name (Provider Billing Name): _____

Provider Group Tax ID (Payment Arrangement ID): _____

How many associated NPI's: _____

How many Provider Practice Locations (approx.): _____

Estimated Claim submission Volume per Month: _____

Do you currently use a clearing house: ☑ **Yes** ☐ **No**

If "Yes", list current clearing house: Zirmed Inc. d.b.a Waystar Health

Requested Effective Date: _____