CREATING HEALTHCARE SOLUTIONS

EDI Claims Enrollment Form Instructions

Identification of Provider/Billing Service/Vendor and Transaction Information

Prior to setting up Electronic Data Interchange (EDI) claims submission with the Alliance, a minimum of one paper claim must have been submitted to the Alliance so that a record for the office can be configured.

Provider Information (All fields are required)	
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider.
Provider Federal Tax Identification Number (TIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), identifies a business entity.
Doing Business As Name (DBA)	Doing Business As Name (DBA).
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
Provider Address - Street	The number and street name where a person or organization can be found.
City	City associated with provider address field.
State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.
ZIP Code/Postal Code	System of postal-zone codes (ZIP stands for "Zone Improvement Plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.
Provider Contact Name	Name of a contact in provider office for handling EDI issues.
Telephone Number	Associated with contact person.
Email Address	An electronic mail address at which the health plan might contact the provider.
Clearinghouse Information (Please select one)	
Clearinghouse	Company that processes claims and sends them out to payers, expediting reimbursement.
Clearinghouse Name	Official name of the provider's clearinghouse.
Billing Service/Vendor Information (Please select one)	
Billing Service/Vendor	A company that supplies EDI services and Practice Management software to the provider.
Billing Service/Vendor Name	Official name of the provider's billing service/vendor.
Submission Information (Please select one)	
Reason for Submission	Select New Enrollment, Change Enrollment, or Cancel Enrollment.
Transmission Information (Select appropriate fields)	
Please specify which EDI transactions (837 Professional Health Care Claim, 837 Institutional Health Care Claim, 835 Health Care Claim Payment/Advice) you would like to setup with the Alliance.	
Authorized Signature (Person submitting form)	
Name	Person submitting form.
Signature	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment.
Submission Date	The date on which the enrollment is submitted.