
AlohaCare (Quest, Medicare) Via RelayHealth

Enrollment Instructions- Professional Claims

- ✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record added.** Please contact your EDI solutions reseller to confirm your EDI account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck provider numbers to be sure they are valid and accurate. Invalid or incorrect provider IDs will cause the enrollment to be delayed or rejected.
- ✓ **Keep a copy of the completed enrollment pages.** Note the date and method of submission. Keep a copy of the completed request in case you should need to follow up or resubmit.

FAX COMPLETED FORMS TO-
Practice Insight, Enrollment Department
713-333-0138

837-CLAIMS Provider Enrollment (New) or (Change of Service)

To authorize Practice Insight as the submitter for electronic claims, complete this form for each billing provider group:

1. HIPAA Transaction Set Form (1 page)
Enter data into section under- **Provider Information**
Enter data into section under- **Provider Contact Information**
2. ON-LINE REGISTRATION FORM - **OPTIONAL** (1 page)
Enter data into section under- **Contact Information**
Signature Required. *See Bottom.*

835- ERAS Electronic Remittance Request (835) (New) or (Change of Service)

Not available at this time.

ALLOW 2-4 WEEKS FOR PROCESSING

If you do not receive confirmation within 30 days, Providers should contact their EDI Reseller/Support Representative. Resellers can call Practice Insight, Enrollment Dept to follow up on this request.



HIPAA Transaction Set Form

PLEASE TYPE or PRINT CLEARLY

(*Denotes a required field)

PROVIDER INFORMATION

*Provider Name: _____

Indicate the Program for EDI Submission: QUEST Medicare

Federal Tax ID: _____ Are you signed up for AlohaCare Online? Yes No

Name of software used for EDI Submission (If not applicable indicate "NA"): NA _____

PROVIDER CONTACT INFORMATION

*Name: _____ *Phone: _____

Email: _____ Fax: _____

*Preferred Method of Contact: Phone Fax Email

CLEARING HOUSE/THIRD PARTY CONTACT INFORMATION

*Name: _____ *Phone: _____

Email: _____ Fax: _____

*Preferred Method of Contact: Phone Fax Email

LIST USERS for EDI TRANSACTIONS (Note: Users must be registered for AlohaCare Online)

1		3	
2		4	

TRANSACTION SET STATUS (please indicate which EDI services you will be testing/using)

Set ID	Transaction Set Description	Ready for Testing (Y/N)	Comments
837P	Professional Claim (HCFA/CMS-1500)	Y	
837I	Institutional Claim (UB92/UB04)	Y	
835	Claim Remittance		
270/271	Eligibility		
276/277	Claim Status		
278	Referral/Authorization		

*REQUIRED INFORMATION for INSTITUTIONAL CLAIMS ONLY

Type of Facility	Fed. ID Number	NPI Number	QUEST Provider ID#	Medicare Provider ID#
Acute				
SNF				
Swing				
Home Health Agency				

Please Fax Completed Form to AlohaCare

Fax Attention to: Provider Relations Department

Oahu: 973-0204 Neighbor Islands/Mainland-Toll Free: 1-866-973-0204



ON-LINE REGISTRATION FORM

PLEASE TYPE or PRINT CLEARLY

(* denotes a required field)

Contact Information

*Provider Name: _____

*Group Name: _____
(If applicable)

*Address: _____
Number/Street City State Zip + (4)

*Contact Name: _____ *Telephone: _____

E-mail Address: _____ Facsimile: _____

QUEST ID#: _____ *Fed Tax ID#: _____

List All Persons in Your Office Who Will Access AlohaCare On-Line

(Please use additional copies of this form if you will have more than 5 authorized users.)

	*User Name <i>(Last Name, First Name)</i>	*Title/Position	Phone Number	Claim Access *(Y/N)	Referral Access *(Y/N)
1					
2					
3					
4					
5					

I authorize the above users to access AlohaCare On-Line for my/our patients. I agree that the users listed above will abide by AlohaCare's Confidentiality Policy, Federal and State regulations applicable to patient privacy, and the confidentiality requirements stated in the Provider Manual. Any violations of these policies, regulations, or requirement may result in loss of privileges, termination of rights, and/or fines. The violations may also be reported to the proper Federal and State regulatory agencies.

*Authorized Signature: _____ *Date: _____

*Print Name: _____ *Title/Position: _____

Please Fax Completed Form to AlohaCare

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