



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms  
6/27/2011 (IE, NF)

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**Community Health Network CT - ERA (62149)**  
**(via Post-N-Track)**  
**Enrollment Instructions – ERA Only**

- ✓ **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 Initial Provider Enrollment (New) or Re-Enrollment (Change of Service)**

No enrollment required.

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

If the provider wishes to authorize Practice Insight to retrieve 835 ERA files, the provider must complete this form:

**1. CHNCT Electronic Remittance Advise Request Form**

This form must be faxed to Practice Insight. Practice Insight will forward on for processing.

**NOTE:** Complete ONLY one form, per billing group (Tax ID #). Do not complete forms for individual providers billing under the same Tax ID #.

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**ALLOW 2-4 WEEKS FOR PROCESSING**

*If it has been over 30 days since request was submitted and you have not yet received confirmation of enrollment, contact your reseller or software support vendor for assistance.*



# Community Health Network of CT

## Electronic Remittance Advise Request

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In order for a provider to receive/deactivate electronic invoice payments from CHN CT, this form must be approved by CHN CT's Provider Informatics & Connectivity Department. After you have completed this document, please email it to [Remits@Post-N-Track.com](mailto:Remits@Post-N-Track.com).

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### **Provider Information**

Please check one Enrollment:  Deactivation:

Provider Name: \_\_\_\_\_ FTIN(s): \_\_\_\_\_

NPI \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Practice Address: \_\_\_\_\_

### **Payment Contact (if different from above)**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_