



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms.
01/20/11(NF,IE)

**EL PASO FIRST Healthplans, Inc.
(via Availity)**

**Medicaid-TX Premier Plan (EPF02), El Paso First-CHIP (EPF03),
Preferred Administrators-TPA (EPF10), HealthCare Options (EPF37)
Enrollment Instructions – Professional and Institutional 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 they are valid and accurate. Invalid or incorrect provider IDs will cause the enrollment to be delayed or rejected.
- ✓ **Make a copy of the completed enrollment pages.** Note the date and method of submission. Place in a file that can be easily referred to, in case you should need to follow up on the edi enrollment request.

**FAX COMPLETED FORM TO-
El Paso First Health Plans
915-298-7867**

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

If the provider has not submitted claims electronically to this payer- or If the provider has been submitting claims to this payer via another clearinghouse and wants to change their service to go through Practice Insight, the provider must complete this for the billing provider group with individual provider Names, TPI #'s and NPI #s.

1. EL PASO FIRST- Electronic Billing Submitter Enrollment Form (2 pages)
“Provider Information”- Complete with Billing Provider information.
“Service Location (1)”, “Service Location (2)” – Complete for 1 or 2 locations.
See “Plan Information”. Put ✓ next to each plan the provider wants to bill electronically.
2nd Page is preprinted with Practice Insight information.

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

Not available at this time.

ALLOW 2-4 WEEKS FOR PROCESSING

If you do not receive confirmation of edi enrollment within 30 days after submitting this request, please contact your support vendor for assistance or call El Paso First Health Plans EDI department direct at 915-532-3778 ext 1504.

EL PASO FIRST

healthplans, inc.

Electronic Billing Submitter Enrollment Form

PROVIDER INFORMATION

Business Name:

Billing Address:

City, State, Zip:

Federal Tax ID #:

Contacts:

Phone: ()

Email:

Service Location (1)

Group TPI#

Address:

City, State, Zip:

Phone Number: ()

Fax Number: ()

Provider Name: (First Last, Title)	Individual TPI #	NPI#

Service Location (2)

Group TPI#

Address:

City, State, Zip:

Phone Number: ()

Fax Number: ()

Provider Name: (First Last, Title)	Individual TPI #	NPI#

(Please include the provider's specialty.)

PLAN INFORMATION: Please check the claim type you plan to bill electronically

- Medicaid- El Paso First Premier Plan (STAR HMO)
- El Paso First - CHIP
- Preferred Administrators – TPA
- Health Care Options (HCO)

R = Required N = Not Used S = Situational based on conditions spelled out in X12 implementation guide or in this requirement guide

CLEARING HOUSE INFORMATION

Clearinghouse: _____ **Phone Number:** () _____
(Vendor Name)
Billing Submitter No. _____

Software: _____ **Phone Number:** () _____
(Vendor Name)
ANSI 4010A1: ____ **Prof** ____ **Inst**

NOTE: This Enrollment Form may not be processed unless you have the provider information listed above. Please fax the form to El Paso First Health Plans (915) 298-7867 to start your enrollment process.

El Paso First Health Plan Use Only:

PROVIDER INFORMATION

Business Name:

PLAN INFORMATION (Unique ID):

El Paso First (STAR HMO) #

El Paso First – CHIP #

Preferred Administrators – TPA #

HealthCARE Options (HCO)

PRODUCTION APPROVAL:

BY:

R = Required N = Not Used S = Situational based on conditions spelled out in X12 implementation guide or in this requirement guide