



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms
12/30/10 (NF, IE)

INDEPENDENT HEALTH (95308)

Buffalo, New York

Enrollment Instructions – Professional Claims and ERA PAYER REQUIRES TESTING FOR ALL PROVIDERS

- ✓ **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.
- ✓ **Make 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.

**Do not send IH enrollment form to the payer.
The signed form must be faxed to Practice Insight.
Fax # 713-333-0138**

**You will be contacted to set up testing required by Independent Health.
Testing must be completed and approved by the payer before
production claims can be submitted.**

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

- Or- If the provider has not submitted claims electronically to this payer-
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 form for each provider sending electronic claims.

1. Electronic Claims Sender Request Form: (1 page)
Add NPI numbers for all the IH providers in your billing group. Attach a separate page if necessary to list the NPI numbers. (Legacy Pin numbers are not needed.)
Select option for "ANSI 835 Remittance" (to enroll to receive electronic remits).

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

If the provider has never registered for ERA files -Or if the provider currently receives 835 ERA files and wishes to authorize Practice Insight to retrieve their 835 ERA files, the provider must select option to receive 835's when completing this form (same form used to enroll for 837-Claims).

1. Electronic Claims Sender Request Form (1 page)
Check the box next to ANSI 835 Remittance.

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 Independent Healthcare EDI at 716-635-3911.



Electronic Claims Sender Request Form

Please fax the completed form to (716) 929-1062. Please contact the E-Commerce call center at (716) 635-3911 if you have any questions.

Please indicate reason for test submission:

New EDI Submitter Software Vendor Change Other: _____

Please indicate the transaction(s) you would like to exchange:

ANSI 837 Institutional ANSI 837 Professional ANSI 837 Dental ANSI 835 Remittance

Date of Request: _____ Office Practice Name: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____

Office Contact Person: _____ Contact Phone Number: _____

Fax Number: _____ E-Mail Address: _____

Please fill out an additional request form for each tax identification number

Office Tax Identification Number: _____

Multiple Offices with same Tax Identification Number: Yes No

Multiple Offices with multiple Sender Id's: Yes No

NPI Numbers: _____

Your Office is: Par Non-Par Your Office is: Primary Specialist Ancillary Billing Service

Will your office be using a Clearinghouse: Yes No

Clearinghouse Name: _____ Clearinghouse Contact: _____

Contact Phone Number: _____ Contact E-Mail Address: _____

Practice Management Software: _____ Contact Person: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E-Mail Address: _____

***** Offices must continue sending production claims while testing to avoid timely filing issues.*****

***** Even if that means billing via paper forms. Signing below acknowledges notification of this.*****

I will continue billing Via: My old system Paper

Office Manager's Signature **X** _____

Test File Requirements:

1. A minimum submission of ten claims per tax identification number.
2. A sufficient claims sample reflective of routine billing.
3. If there are multiple providers within a group, claims from at least two providers are required.

***** office use only *****

Sender ID: _____ Implementation Date: _____ Orientation Date: _____

Submission Method: Web Upload Dial FTP Internet FTP

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