
**VA Premier Health Plan Inc. - (VPN01)
(via Capario)
Enrollment Instructions – Professional Claims 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 customer account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck to make sure provider ID #s are valid. 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 submitted paperwork, in case you need to follow up on your request.

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

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

If the provider has NOT submitted electronic claims to this payer before, or if the provider wishes to request a CHANGE of SERVICE to authorize Practice Insight to submit claims the billing provider must complete and submit these forms:

1. Practice Insight 837-Claims Provider Enrollment Form (1 Page)
Enter Billing Provider Information
2. VA Premier Health Plan EDI 837 Claims Enrollment Form (2 Pages)
Section 3 - Enter Provider Group Information
Section 4 - Enter Provider Billing Address
SEE Table - Enter Billing Provider Information

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 complete these forms:

The option is not available at this time.

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.



Fax completed forms to
Practice Insight
713.333.0138

837-Claims Provider Enrollment Form

Provider Information						
Provider Name:						
Billing NPI:		Tax ID:		Exclusive Provider ID: (If Applicable)		
Telephone Number:			Fax Number:			
Primary Address:						
City			State:		Zip:	
Billing Address:						
City:			State:		Zip:	
Contact Information						
Contact Name:						
Telephone Number:			Email:			
EDI Information						
Support Vendor / Reseller:				EDI Cust #:		
Payer Name:				Payer #:		
Receiver Information						
Receiver Name:	Practice Insight, LLC					
Telephone Number:	713.333.6000		Fax Number:	713.333.0138		

Please Allow 2-4 Weeks For Processing



EDI 837 Claims Enrollment Form

(To Send Electronic Claims to VPHP)

Date _____

1 Submitter Information (to be filled out by the clearinghouse)		
CLEARINGHOUSE		
Clearinghouse Contact Name		
Clearinghouse Address		
City	State	Zip
Phone	Email	
<i>[Note: VPHP will send enrollment confirmation to the email address above.]</i>		
2 Billing Agent/Service Information [refers to the clearinghouse]		
Billing Agent Tax ID	[REDACTED]	
3 Provider Group Information (W-9 Required)		
Group Name		
Group Tax ID		
Group NPI # (if applicable)		
4 Provider Remittance/Billing Address		
Address		
City	State	Zip

Internal Use	
ID#	_____
W-9 on file	_____
Database	<input type="checkbox"/>
FAX	<input type="checkbox"/>
E-Mail	<input type="checkbox"/>
Date	_____

PROVIDER NAME (Including TITLE) (e.g. MD, DO, DPM)	PROVIDER SPECIALTY (e.g. Family Practice)	PROVIDER NPI # (10 Digits)	PROVIDER TAXONOMY CODE	PAR (Participating) Or Non-Par

