Payer ID: 95308

# Independent Health
# 837 and 835

**EDI Enrollment Instructions:**

- Please save this document to your computer. Open the file in the Adobe Reader program and type directly onto the forms.
- Complete the forms using the provider's **billing/group information as credentialed** with this payer.
- Once completed, save for your records, print and obtain appropriate signature(s).
- EDI enrollment processing timeframe is approximately **10 business days**.
- To check status of EDI enrollment, please contact **Independent Health at 716-635-3911**.

**837 Claim Transactions and 835 Electronic Remittance Advice:**

**Electronic Claims Sender Request Form**
Complete all applicable fields.
Check the box next to **'ANSI 837 Institutional'** or **'ANSI 837 Professional'** depending on the type of claims you will be submitting.

**Electronic Transaction Agent Designation Letter**
Complete all applicable fields.
Provider or Authorized Agent must print name, date, address, Tax ID, telephone number and sign where indicated.

**EDI Enrollment Form- Application for Electronic Remittance Advice 835 (ERA)**
Complete all applicable fields.
Check the box next to **'New Enrollment'** or **'Change Enrollment'** within the **'Section 10- Submission Information'** section.
Provider or Provider's Representative must print name, title, date, and sign where indicated.

**Submit Completed Document:**

**Fax to** Independent Health
**716-929-1062**

# 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 with any questions.**

**Please indicate reason for request:**

☑ New EDI Submitter ☐ Software Vendor Change ☐ Other: _____

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

☐ ANSI 837 Institutional ☐ ANSI 837 Professional

Office Practice Name: _____ Date of Request: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____

Office Contact Person: _____ Contact Phone Number: _____

Fax Number: _____ E-Mail Address: _____

Tax ID#: _____ NPI Number(s): _____

Multiple Offices with same Tax ID#: ☐ Yes ☐ No

Multiple Offices with multiple Sender Id's: ☐ Yes ☐ No

Will your office be using a Clearinghouse: ☑ Yes ☐ No

Clearinghouse Name: **ClaimRemedi** Clearinghouse Contact: **Linda Burton**

Contact Phone Number: **866-633-4726** Contact E-Mail Address: **Lburton@esolutionsinc.com**

Practice Management Software: _____ Contact Person: _____

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

Phone: _____ E-Mail Address: _____

Desired Submission Method: ☐ Web Upload ☐ SSL with PGP Encryption ☐ SFTP with PGP Encryption ☐ CORE – HTTP MIME Multipart ☐ CORE – SOAP + WSDL

**Please contact the eCommerce Call Center at (716) 635-3911 with any questions.**

# Electronic Transaction Agent Designation Letter

Independent Health Association, Inc. Date: _____
Attn: e-Commerce Dept.
511 Farber Lakes
Buffalo, New York 14221

Dear Sir or Madam:

I, _____ (Authorized Agent for Covered Entity), authorize **ClaimRemedi** (Clearinghouse/Payment Processor) to exchange electronic files and access electronic documents, as described below, with Independent Health Association, Inc. for _____ (Covered Entity).

I further certify that a valid Business Associates Agreement is in effect between: (1) the **ClaimRemedi** (Clearinghouse/Payment Processor) and _____ (Covered Entity) and its subsidiaries and (2) _____ (Covered Entity) and _____ (Authorized Agent for Covered Entity).

We are requesting access to the following types of files to exchange and/or review:

☑ 837 Electronic Claim Files and Response Files

☑ 835 Electronic Remittance Advices

☐ Electronic Documents on Reveal (Requires Reveal Intake Form & User Agreement)

Sincerely,

_____ _____
Signature of Authorized Agent for Covered Entity Date

_____ _____
Printed Name of Authorized Agent for Covered Entity Tax ID

_____ **837P -jjg, 837I nrz**
Address Submitter/Trading Partner ID

_____
City, State, Zip Code

_____
Telephone Number (including Area Code)

*Please fax this letter to (716) 929-1062. No information will be released to the Clearinghouse/Payment Processor until a signed letter is returned to Independent Health.*

# EDI Enrollment Form for Medical Claims

## Application for Electronic Remittance Advice 835 (ERA)

Independent Health: Electronic Remittance Advice (ERA) Authorization Agreement

* *Indicates a required field.*

## Section 1 – Provider Information:

* **Provider Name:**

**Doing Business As Name (DBA):**

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* **Provider Address:**

* **Street:**

* **City:** * **State/Province:** * **Zip Code/Postal Code:**

**Country Code:**

---

## Section 2 – Provider Identifiers Information:

### Provider Identifiers

* **Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)**

* **National Provider Identifier (NPI):**

---

### Other Identifier(s)

* **Assigning Authority:** ClaimRemedi **Trading Partner ID:**

**Provider License Number:** **License Issuer:**

**Provider Type:** **Provider Taxonomy Code:**

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## Section 3 – Provider Contact Information:

* **Provider Contact Name:**

**Title:**

* **Telephone Number:** **Telephone Number Extension:**

# EDI Enrollment Form for Medical Claims

## Application for Electronic Remittance Advice 835 (ERA)

*** Email Address:** **Fax Number:**

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## Section 4 - Provider Agent Information:

*** Provider Agent Name:**

*** Street Address:**

*** City:** *** State:** *** Zip:**

**Contact Name:**

**Title:**

**Telephone #:** **Fax #:**

**E-mail Address:**

## Section 7 – Electronic Remittance Advice Information:

***** *Must select one of the following*:

| * Billing NPI Number | Name of Billing Provider |
|---|---|
| | |
| * Billing Tax ID Number | Name of Billing Provider |
| | |

**Method of Retrieval:** * *Must select one of the following*:

☑ **Internet FTP** ☐ **Secure FTP** ☐ **Transaction Assistant**

## Section 8 – Electronic Remittance Advice Clearinghouse Information

*** Clearinghouse Name:** ClaimRemedi

**Clearinghouse Contact Name:**

**Telephone Number:**

**Email Address:** **Fax Number:**

# EDI Enrollment Form for Medical Claims

## Application for Electronic Remittance Advice 835 (ERA)

## Section 9 – Electronic Remittance Advice Vendor Information:

* **Vendor Name:**

**Vendor Contact Name:**

**Telephone #:**

**E-mail Address:**

## Section 10 – Submission Information:

* **Reason for submission:**

☐ New Enrollment (request for a new trading partner number)

☐ Change Enrollment

☐ Cancel Enrollment

* **Authorized Signature** - A signature is required from either the provider or an authorized provider representative. Only one billing provider may be enrolled per form.

Provider or Provider's Representative

(Sign)

(Print)

(Print Title)

Click here to enter a date.

(Date)

**Completed EDI enrollment forms may be emailed to:** e-commerce@independenthealth.com

**Or faxed to:** 716-929-1062

**Or mailed to:** Independent Health
ATTN: eCommerce
511 Farber Lakes Drive
Buffalo, NY 14221