

## US Family Health Texas & Louisiana 835

### EDI Enrollment Instructions:

- Please save this document to your computer. Open the file in the Adobe Reader program and type directly onto the form.
- Complete the form using the provider's billing/group information as credentialed with this payer.
- Once completed, save, print and submit to ClaimRemedi for processing.
- EDI enrollment processing timeframe is approximately 10 business days.
- To check status of EDI enrollment, please contact US Family Health at 800-678-7347.

### 837 Claim Transactions:

EDI Enrollment applies to ERA only and is not necessary prior to sending claims.

### 835 Electronic Remittance Advice:

#### 835 EDI Enrollment Form

Complete the form as appropriate, using provider's billing/group information as credentialed with this payer.

### Submit Completed Document.

Fax or Email to your clearinghouse with this cover page and **current W-9**.

The clearinghouse will forward onto the Payer for processing.

#### 1. Email to both:

[chpimsupport@christushealth.org](mailto:chpimsupport@christushealth.org) AND  
[ESH@claimremedi.com](mailto:ESH@claimremedi.com)



## 835 EDI ENROLLMENT FORM

Healthcare providers who are interested in receiving 835s from the US Family Health for Texas and Louisiana must complete the attached application and follow the directions as set forth below.

**Please note:** In order to be enrolled to receive 835s from the US Family Health Plan in Houston, a healthcare provider must have provided services to a US Family Health Plan member who resides either in the state of Texas or Louisiana.

Providers will not be added into the Plan's system if they have not provided services to a US Family Health Plan member residing in either Texas or Louisiana. If a provider has seen a US Family Health Plan member from another region (i.e., New York, Maine, etc.), the provider needs to contact and register with the US Family Health Plan for that region. Information regarding each region can be found at [www.usfhp.com](http://www.usfhp.com).

**Please follow the directions below:**

1. In order to perform 835 transactions with the US Family Health Plan, you will need a GENKEY from the clearinghouse Availity. If you do not currently have a GENKEY, please go to [www.Availity.com](http://www.Availity.com) and you will be able to sign-up for a GENKEY with no charge to you.
2. Next, please complete the attached form. Section I should include information at the highest level for the provider. Section II should include all providers for which a claim will be submitted. For example, physician groups should include information regarding the group in Section I and then include all the individual physicians included in the group in Section II. Healthcare providers include solo practitioners, allied healthcare professionals, groups, facilities and ancillary providers.

**Please Note:** If you are a solo practitioner or an individual provider, you only need to complete Section I.

3. Once the attached form is completed, ***please forward the form and a copy of your current 2011 W-9 to your clearinghouse or billing service.***
4. Your clearinghouse/billing service will then need to forward your completed EDI Form and the copy of your current 2011 W-9 to the US Family Health Plan either via fax to 469-282-3013 or it can be sent via e-mail to [USFHPEDI@usfhpchristus.org](mailto:USFHPEDI@usfhpchristus.org).
5. Once the EDI Form and your current 2011 W-9 are received by the US Family Health Plan and you, the provider, have been set up in the Plan's system, the Plan will notify your clearinghouse/billing service via e-mail that you are ready to begin receiving 835 transactions with our Plan.
6. Should you or your clearinghouse/billing service have any questions regarding the above process, you can contact the US Family Health Plan's EDI Specialist at 469-282-3066 or via e-mail at [USFHPEDI@usfhpchristus.org](mailto:USFHPEDI@usfhpchristus.org).

Section I

Date:	<input type="checkbox"/> MD	<input type="checkbox"/> DO	<input type="checkbox"/> DPM	<input type="checkbox"/> Other:
Which form do you use to submit claims?	<input type="checkbox"/> HCFA-1500		<input type="checkbox"/> UB-04	
Provider/Facility Name:				
Provider Address :				
Provider City/State/Zip:				
Business Name as indicated on current 2011 W-9:				
Provider Tax Identification Number (TIN):		NPI 1 (if applicable):		NPI 2 (if applicable):
Provider Office's Contact Name:			Phone Number for Office Contact:	
Provider E-mail Address:				
Billing Service/Clearinghouse Name:				
Billing Service/ Clearinghouse Contact Name:		Billing Service/Clearinghouse Phone Number:		
Billing Service/ Clearinghouse E-Mail Address:				
Availity Customer ID : (Required)				

Section II

Please list each individual provider's name and their corresponding NPI 1 or NPI 2 in the space provided below.  
(If necessary, please continue list on a separate piece of paper).

Provider Name	NPI

\*\*\*For Office USFHP Use Only\*\*\*

- INN                       ONN
- Network/Region**
- ALL     CYPR     STCA     STJN     STJO
- SETX     SGLN     MMCN     WLBN     LALC

**Network Representative**

- V, Melancon     E.DeMien     M. Harris
- E.Howard-Provost     K.Pace

Contact Validation \_\_\_\_\_

Contact Phone Number \_\_\_\_\_

Validation Date \_\_\_\_\_

**Notes:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date given to EDI Specialist: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_