

Aetna Better Health of Kentucky

835

EDI Enrollment Instructions:

- Complete the enrollment using the provider's billing/group information as credentialed with this payer.
- Once completed, save for your records, print and obtain appropriate signature.
- EDI enrollment processing timeframe is approximately 30 business days.
- Online enrollment through the payer's website is required.

835 Electronic Remittance Advice:

Step 1: Complete the Online Enrollment:

Log in to the payer's website at <https://payerenrollservices.com/>.

Select **'Begin Enrollment'** to create a login. If you already have a login, select **'Sign In.'**

Once you have logged in, you will be taken to the **'Provider Information'** screen. Enter in all the requested information, then click **'Continue.'**

On the **'Provider Contact Information'** screen, enter in all the requested information then click **'Continue.'**

On the **'Bank Information'** screen, answer **'Yes'** if you wish to enroll for EFT. If not, answer **'No'** then click **'Continue.'**

If you answered **'Yes'** to the prompted question, click **'Add Bank.'** Enter in all the requested information, then click **'Submit.'**

You must then attach a voided check or bank letter. Attach the file, then hit **'Submit.'**

On the **'Enrollment'** screen, click **'Add Enrollment.'**

From the **'Payer'** dropdown, select **'Aetna Better Health.'** Check the box to accept the acknowledgement, then click **'Continue.'**

Under **'Service Selection,'** check **'ERA'**. If you are enrolling for EFT too, check **'EFT.'**

Click the circle next to **'TIN & NPI(s).'** Enter the NPI(s) you wish to enroll, enter the effective date of the enrollment, then click **'Continue.'**

Under the **'ERA Information'** screen, click the **'Clearinghouse'** drop-down, select **'Change CHANGE HEALTHCARE (Emdeon/WebMD).'** Enter **Trading Partner ID '133052274.'**

If you selected EFT, you will be prompted to confirm your bank account. Click **'Submit'** to confirm.

Step 2: Complete the Change Healthcare Cover Page(s)

Once the online enrollment has been submitted, complete all applicable fields.

Submit Completed Document:

1. Fax or Email to Change Healthcare.

Email: batchenrollment@changehealthcare.com

Fax: 6158853713

NOTE: There are two Change Healthcare Remittance forms enclosed. Only submit the form applicable to the **Type of Business** you are credentialed for: Professional or Institutional. Only submit both if your practice is credentialed for both types of business.

Payer Information					
CPID	Payer ID	Payer	Type	Est Days	Multi CH
Special Enrollment Instructions					
Vendor Information					
Submitter ID	Submitter Name				
Provider Information					
Tax ID	NPI	Provider Number	Name		
Address			City	State	Zip
Contact Name				Contact Phone	
Contact Email Address					
Confirmation Addresses					
Primary Email Address			Secondary Email Address		
ERA Receiver					
Distribution Detail					

Provider Name: _____

Address: _____

City: _____ State: _____ Zip: _____

TAX ID: _____ NPI: _____

Contact First Name: _____ Contact Last Name: _____

Contact Phone Number: _____

Contact Email: _____

Name of the Person that submitted the agreement on Payer Enroll Services: _____

Payer Information					
CPID	Payer ID	Payer	Type	Est Days	Multi CH
Special Enrollment Instructions					
Vendor Information					
Submitter ID	Submitter Name				
Provider Information					
Tax ID	NPI	Provider Number	Name		
Address			City	State	Zip
Contact Name				Contact Phone	
Contact Email Address					
Confirmation Addresses					
Primary Email Address			Secondary Email Address		
ERA Receiver					
Distribution Detail					

Provider Name: _____

Address: _____

City: _____ State: _____ Zip: _____

TAX ID: _____ NPI: _____

Contact First Name: _____ Contact Last Name: _____

Contact Phone Number: _____

Contact Email: _____

Name of the Person that submitted the agreement on Payer Enroll Services: _____