Payer ID: 04293

Allways Health Partners
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 for your records, print and obtain appropriate signature(s).
- EDI enrollment processing timeframe is approximately **15 business days.**
- To check status of EDI enrollment, please contact **AllWays Health at 857-282-3004**.

837 Claim Transactions:

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

835 Electronic Remittance Advice:

Allways Health Partners Electronic Remittance Advice Enrollment Form

Complete the form as appropriate.

Submit Completed Document:

Fax to Allways Health Partners,

Attn: EDI Team

617-526-1920

Electronic Remittance Advice Authorization Agreement

Fields marked * are required

Provider Information

*Provider Name: _____

*Provider Street Address: _____

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

Provider Federal Tax ID Number (TIN) or Employer Identification Number (EIN): _____

*National Provider Identifier (NPI): _____

Assigning Authority: _____

Trading Partner ID: 460477436

Provider Contact Information

*Provider Contact Name: _____

*Telephone Number: _____ Fax Number: _____

Email Address: _____

Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier):

- ○ Provider Tax Identification Number (TIN)
- ◉ National Provider Identification Number (NPI)

Method of Retrieval:

- ○ Direct Retrieval
- ◉ Clearinghouse
- ○ Billing Service

ERA Clearinghouse Information

Clearinghouse Name: ClaimRemedi

Telephone Number: 866-633-4726 Email: enrollment@claimremedi.com

Reason for Submission:

- ☐ New Enrollment
- ☐ Change Enrollment
- ☐ Cancel Enrollment

Authorized Signature

Signature of Submitter: _____

Printed Title of Person Submitting Enrollment: _____

Submission Date: _____ Requested ERA Effective Date: _____

Provider Information (Please Fill Out Completely)

- Provider Name – Complete legal name of institution, corporate entity or individual billing provider
- Provider Street Address – The number and street where the person or organization can be found
- City – City associated with the provider address
- State/Province – Two character postal abbreviation
- Zip Code/Postal Code – Postal Zip Code

Other Identifiers:

- Assigning Authority – Not Used by AllWays Health Partners
- Trading Partner ID – If you are a direct submitter/retriever of Claims/ERA's please enter your Claims file ISA06 value or your ERA (835) ISA08 value. If you use a clearinghouse, please enter the clearinghouse name.

Provider Contact Information

- Provider Contact Name – Name of contact in the provider's office handling EFT issues
- Telephone Number – Contact's telephone number with extension if applicable
- Fax Number – A number where the provider's office can be sent FAX documents
- Email Address – Contact's email address

Preference for Aggregation of Remittance Data (Grouping of Payment Information which must match preference for EFT payment)

- Provider's Tax ID Number (TIN) – This is not an option as AllWays Health Partners pays by Billing NPI Number
- National Provider Identifier (NPI) – Billing NPI number must be used

Method of Retrieval

- Direct Retrieval – You have established a trading partner agreement with AllWays Health Partners
- Clearinghouse – Please complete the clearinghouse information below
- Billing Service – Please make sure that the Billing Service's Trading Partner Name is listed under Other Identifiers above.

Electronic Remittance Advice Clearinghouse Information

- Clearinghouse Name – Name of the Clearinghouse Authorized to receive your ERA (835) files
- Telephone Number – Clearinghouse telephone number
- Email Address – Clearinghouse email address

Reason for Submission

- New Enrollment – If you currently do not receive an ERA(835) file from AllWays Health Partners and are requesting one
- Change Enrollment – If you currently receive an ERA(835) from AllWays Health Partners and want to change the recipient of the file (i.e changing from a clearinghouse to direct retrieval, changing form one clearinghouse to another)
- Cancel Enrollment –If you wish to stop receiving ERA(835) from AllWays Health Partners

Authorized Signature

- Signature of Submitter – Signature of an individual authorized by the provider or its agent to initiate, modify or cancel enrollments.
- Printed Title of Person Submitting Enrollment – Authorized Individual's Business Title
- Submission Date – Date the form was completed
- Requested ERA Effective Date – Any date less than 30 days from the Submission Date will be added to the next payment cycle. Any date that is more than 30 days from the Submission Date will be added on the requested date.

The completed form can be faxed to EDI Enrollment at:
617-526-1920, ATTN: EDI Team

If you have any questions concerning this form or the status of your submitted form, please call 857-282-3004.

The completed form can be mailed to:
AllWays Health Partners
ATTN: EDI Team
399 Revolution Drive, Suite 810
Somerville, MA 02145

Researching Missing/Late Files

ERA files that have not been received after 4 business days of receipt of the corresponding EFT file, can be researched by calling 857-282-3004.