Payer ID: 84367

Braven Health
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 setups are generally completed in approximately **14 business days.**

837 Claim Transactions:

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

835 Electronic Remittance Advice:

Braven Health Electronic Remittance Advice (835) Enrollment

Complete all applicable fields.

Under Submission Information – Reason for submission (select one from below):

Be sure to select only one reason for submission.

Submit Completed Documents:

Email all pages to eSolutions to compete the setup. Do not submit direct to the payer.

ESH@claimremedi.com

Reset

BRAVEN HEALTH
Electronic Remittance Advice (835) Enrollment

To participate in the Braven[SM] Health Electronic Remittance Advice (ERA/835) program, please email this completed form to BravenEDI@BravenHealth.com or fax this completed form to **1-973-522-4665**.

If you are using a Trading Partner to perform ERA/835, that Trading Partner **MUST BE** an authorized Braven Health ERA Trading Partner. To obtain a list of authorized Trading Partners, please email a request to BravenEDI@BravenHealth.com.

The Braven Health Payer ID is **84367.**

Provider Information Section

Provider Name: _____

Provider Street Address: _____

City:_____State/Province: _____ZIP Code/Postal: _____

Provider Identifiers Information

Six-Digit UPIN: _____ NPI: _____

Tax Identification Numbers (TIN): _____
Include all TIN suffixes as appropriate

Provider Contact Information Section

Provider Contact Name: _____

Telephone: _____ Email: _____

Electronic Remittance Advice Information

Aggregation of Remittance Data:

TIN: _____ NPI: _____

Method of Retrieval (*The method by which the provider will receive the ERA from the health plan)*

☐ Download from health plan website

☒ Clearinghouse/Vendor

☐ Other _____

835B (0820)

Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name: Waystar

Clearinghouse Contact Name: Enrollment Representative

Telephone: 877-494-7633 Email: enrollment@waystar.com

Electronic Remittance Advice Vendor Information

Vendor Name: _____

Vendor Contact Name: _____

Telephone: _____ Email: _____

Submission Information

Reason for Submission (select one from below)

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

Authorized Signature

Name: _____

Title: _____

Signature: ☒ _____

Date: _____