Payer ID: 95491

# CDPHP
# 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 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 30 business days, to be included in the next ERA payment schedule.
- To check status of EDI enrollment, please contact CDPHP Provider Relations at E_Transaction_Help@cdphp.com .

**837 Claim Transactions:**

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

**835 Electronic Remittance Advice:**

**CDPHP 835 Electronic Remittance Advice (ERA) Enrollment Request**

Complete the form as appropriate.

**Submit Completed Document:**

**Email or Fax** to CDPHP

**EFax_835@cdphp.com**

**518-641-3301**

# 835 Electronic Remittance Advice (ERA) Enrollment Request

Please complete this form to initiate receipt of electronic claim remittance voucher statements from CDPHP® via the 835 transaction set and **FAX to (518) 641-3301** or save as PDF and attach to email to **EFax_835@cdphp.com**. Large provider groups with multiple tax numbers and/or billing NPI numbers must complete a separate form for each tax/billing NPI combination.

Please direct questions about completing this form or matters concerning connectivity to the CDPHP Provider Relations team at **E_Transaction_Help@cdphp.com**.

**Today's Date:** _____

◯ **New Enrollment** ◯ **Change Enrollment** ◯ **Cancel Enrollment**

## Section I Provider Identification

Provider Name: _____

National Provider Identifier (NPI) #: _____ Tax Identification/EIN #: _____

Address 1: _____

Address 2: _____

City, State, Zip Code: _____

## Section II Provider Business Office Contact Information

Business Contact Name: _____ Title: _____

Telephone: _____ Ext.: _____ Fax: _____

E-mail Address: _____

## Section III Technical Contact Information (if applicable)

Clearinghouse/Agent/Vendor Name: **eSolutions, Inc. (FKA ClaimRemedi)**

Telephone: **866-633-4726** Ext.: _____

E-mail Address: **Enrollment@claimremedi.com**

Which tax ID number will you be submitting under?: **460477436**

*Complete the following only if you will have a third-party vendor retrieving your 835 transactions from CDPHP:*

I authorize **eSolutions, Inc. (460477436)** to act as my agent to view Capital District Physicians' Health Plan, Inc. (CDPHP), Capital District Physicians' Healthcare Network, Inc. (CDPHN), or CDPHP Universal Benefits, Inc. (CDPHP UBI) member data, including possible protected health information (PHI), in any format deemed appropriate by CDPHP, CDPHN, or CDPHP UBI, on my behalf. The entity listed above is my authorized business associate. I authorize the entity listed above to receive correspondence related to the submission and processing of ANSI X12 835 transactions on my behalf.

Signature: _____ Date: _____

Title: _____ Employer: _____

Print Form