eSolutions
Strengthen your revenue health

Payer ID: 95311

Central California
Alliance for Health
837

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.
- Complete an enrollment form for **each billing NPI provider number**.
- Once completed, save for your records, print and obtain appropriate signature(s).
- **835 Enrollment will be completed through ECHO. See the separate enrollment packet for 835.**
- EDI enrollment processing timeframe is approximately **10 business days**.
- To check status of EDI enrollment, please contact **Central CA Alliance at edisupport@ccah-alliance.org**

837 Claim Transactions:

<u>**EDI Claims Enrollment Form**</u>
Complete all fields, as applicable.

Submit Completed Document:

Email or Fax to Central California Alliance for Health,
ATTN: EDI Analyst
edisupport@ccah-alliance.org
831-430-5895

EDI CLAIMS ENROLLMENT FORM

IDENTIFICATION OF PROVIDER/TRADING PARTNER AND TRANSACTION INFORMATION

All Trading Partners, whether covered entities or business associates of covered entities, agree to abide by all HIPAA Privacy and Security requirements as they apply to communications with The Alliance.

Reminder: Prior to setting up Electronic Data Interchange (EDI) claims submission with the Alliance, a minimum of one paper claim must have been submitted to the Alliance so that a record for the office can be configured.

PROVIDER INFORMATION (All fields required)

Provider Name		Provider Federal Tax Identification Number (TIN)	
Doing Business As Name (DBA)		National Provider Identifier (NPI)	
Provider Address – Street	City	State/Province	ZIP Code/Postal Code
Provider Contact Name	Telephone Number ( )	Email Address	

CLEARINGHOUSE INFORMATION (Required field)

Are you planning to use a clearinghouse for electronic transmissions with the Alliance?	Clearinghouse Name

SUBMISSION INFORMATION (Required field)

Reason for Submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

TRANSMISSION INFORMATION (Select appropriate fields)

☐ **Professional (837)** (ASC X12N 005010X222)	☐ **Institutional (837)** (ASC X12N 005010X0223)

AUTHORIZED SIGNATURE (Person submitting form)

Name	Signature	Submission Date

Please EMAIL completed form to
edisupport@ccah-alliance.org

Or FAX to (831) 430-5895, ATTN: EDI Analyst

To enroll in electronic claims submissions, please contact our EDI Support Unit by emailing a completed EDI Claims Enrollment form edisupport@ccah-alliance.org

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To enroll in Electronic Remittance Advice(ERA), contact our partner ECHO Health at EDI@echohealthinc.com or call (888) 983-5574.