Payer ID: CCHP
WSPID: Z1800

Contra Costa Health Plan
835

EDI Enrollment Instructions:

- 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).
- ERA enrollment processing timeframe is approximately 30 business days.
- EFT enrollment is required to receive ERAs from this payer.
- Once the payer receives the form, they will reach out to the enrollment contact for testing and financial institution verification.

835 Electronic Remittance Advice:

Provider Direct Deposit Authorization Agreement

Complete the form as appropriate, using the information provided below.

Complete all applicable fields.
In the EFT Enrollment section, select if this is a 'New Enrollment' or a 'Change/Add Enrollment Information.'
Complete the Depository Information section by checking if you will be using a 'Business Checking Account' or a 'Business Savings Account. Then fill in the Financial Institution name, routing number, account number, and address.
You must include a voided check or canceled deposit slip with the agreement in order to be setup with EFT.
Provider or Authorized Person must print name, date, email and sign where indicated.

Submit Completed Documents:

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

ESH@claimremedi.com

Contra Costa Health Plan
Analysis & Reporting Unit
1340 Arnold Dr., Suite 125
Martinez CA 94553
(925) 313-7103

Provider Direct Deposit Authorization Agreement

Contra Costa Health Plan (CCHP) is improving its services by offering to replace paper checks and Explanation of Benefits (EOBs) with Electronic Payments and Benefit Statements. Please use this form to enroll your vendor and/or provider data; complete all fields and fax to 925-957-5101 or email to EDISupport@cchealth.org.

After CCHP is in receipt of the enrollment application, additional instructions for testing and financial institution verification will be provided. Please allow 4-6 weeks before receipt of electronic deposits.

Check One: EFT Enrollment		
☐ New Enrollment	☐ Change/Add Enrollment information	☐ Cancel/Discontinue

Provider Information			
Provider Name (legal):			
Address:			
City, State, Zip:		Telephone#:	

Provider Identification			
TIN# or EIN#:		NPI#:	
Fax#: (to receive EOB report)		Clearinghouse: Availity	

Check One: Depository Information		
☐ Business Checking Account	☐ Business Savings Account	
Financial Institution Name:		
Routing Number (9 digits):		
Account# (up to 14 digits):		
Address:		
City, State, Zip:	Telephone#:	

[[please attach a “canceled check” or “canceled savings deposit slip” to this signed enrollment form]]

Authorization

The undersigned hereby certifies that the information provided is true and accurate in all respects and that he/she is duly authorized to execute this agreement on behalf of the above listed organization.

Authorizer Name (printed):	
Signature:	
Date	
Enrollment Confirmation Email:	
Telephone#:	

For internal use only

CCHP Vendor#:		Incident Ticket#:	
CCHP Processed By:		Auditor’s Setup By:	
Date:		Date:	