eSolutions
Strengthen your revenue health

Payer ID: EPF02, EPF03,
EPF10, EPF11, EPF37

El Paso First
Health Plans
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).
- **Include a W9 with this form submission.**
- EDI enrollment processing timeframe is approximately **15 business days**.
- To check status of EDI enrollment or for assistance with completing the form, please contact **El Paso Health at 915-532-3778, Ext. 1507.**

837 Claim Transactions:

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

835 Electronic Remittance Advice:

Electronic Remittance Advice (835) Request Form
Complete all applicable fields.

NOTE: After submission of the Electronic Remittance Advice Request Form, a test file will be sent to ensure the successful transmission of the 835 file. **Please note that the test file must be confirmed, by the provider, before the process can be completed**. Failure to confirm the test file within 30 calendar days will cause the request to be closed and a new request will need to be submitted.

Submit Completed Document:
Fax form with W9 to
915-225-6762

El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

Electronic Remittance Advice (835) Request Form

915.532.3778 ext. 1507 • Fax: 915.225.6762

BILLING PAY TO PROVIDER INFORMATION (PLEASE INCLUDE W9)

Official Business Name: ____

Doing Business As: ____

Billing Address: ______________________________ City: ______________ State: _____ Zip: ________

Federal Tax ID: _______________________________ Group NPI: _______________________________

Primary Contact: _____________________Phone: ________________ Email: _____________________

PROVIDER INFORMATION

Primary Service Location: ____

Address: __________________________________ City: _______________ State: _____ Zip: ________

Phone: _____________________Fax: ________________ Website URL: ________________________

CLEARINGHOUSE INFORMATION

Clearinghouse Name: ____ Phone: _________________

*Availity Customer ID# (**Genkey**): _____________________ Billing Submitter Number: _________________

Software Vendor Name: ____ Phone: _________________

***Genkey is required for Availity.**

AUTHORIZATION STATEMENT SIGNATURE

Provider *(enter provider/provider representative name)* ________________ hereby appoints *(enter vendor name)* ___________________ to act as the authorized agent for the purpose of retrieving the 835 electronically from El Paso Health.

Provider/Provider Representative Signature: ________________________________ Date: _____________

EL PASO HEALTH PAYER IDs

Plan	Payer ID
El Paso First Health Plans Premier Plan STAR Medicaid HMO	Availity/ Trizetto Provider Solutions Payer ID: EPF02
El Paso First Health Plans CHIP	Availity/ Trizetto Provider Solutions Payer ID: EPF03
El Paso First Health Plan HCO Healthcare Options	Availity/ Trizetto Provider Solutions Payer ID: EPF37
Preferred Administrators	Availity/ Trizetto Provider Solutions Payer ID: EPF10
Preferred Administrators Children’s Hospital	Availity/ Trizetto Provider Solutions Payer ID: EPF11

CONFIRMATION OF TEST FILE

After submission of the Electronic Remittance Advice Request Form, a test file will be sent to ensure the successful transmission of the 835 file. Please enter the contact information for the representative that will be able to confirm receipt of the test file. Please note that the test file must be confirmed before the process can be completed. Failure to confirm the test file within 30 calendar days will cause the request to be closed and a new request will need to be submitted.

Contact Name: _____________________ Phone: ______________ Email: _________________________