eSolutions
Strengthen your revenue health

Payer ID: 95308

Independent Health
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 forms.
- Complete the forms 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 **10 business days**.
- To check status of EDI enrollment, please contact **Independent Health at 716-635-3911**.

837 Claim Transactions and 835 Electronic Remittance Advice:

Electronic Claims Sender Request Form
Complete all applicable fields.

Electronic Transaction Agent Designation Letter
Complete all applicable fields.

Submit Completed Document:

Fax to Independent Health
716-929-1062

Electronic Claims Sender Request Form

Please fax the completed form to (716) 929-1062. Please contact the E-Commerce call center at (716) 635-3911 if you have any questions.

Please indicate reason for test submission:
☐New EDI Submitter ☐Software Vendor Change ■Other: clearinghouse direct connect

Please indicate the transaction(s) you would like to exchange:

☐ANSI 837 Institutional ☐ANSI 837 Professional ☐ANSI 837 Dental ☐ANSI 835 Remittance

Date of Request: _____ Office Practice Name: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____

Office Contact Person: _____ Contact Phone Number: _____

Fax Number: _____ E-Mail Address: _____

Please fill out an additional request form for each tax identification number

Office Tax Identification Number: _____

Multiple Offices with same Tax Identification Number: ☐Yes ☐No

Multiple Offices with multiple Sender Id's: ☐Yes ■No

NPI Numbers: _____

Your Office is: ☐Par ☐Non-Par Your Office is: ☐Primary ☐Specialist ☐Ancillary ☐Billing Service

Will your office be using a Clearinghouse: ■Yes ☐No

Clearinghouse Name: ClaimRemedi Clearinghouse Contact: Linda Burton

Contact Phone Number: 866-633-4726 Contact E-Mail Address: Lburton@esolutionsinc.com

Practice Management Software: _____ Contact Person: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E-Mail Address: _____

***** Offices must continue sending production claims while testing to avoid timely filing issues.*****

*****Even if that means billing via paper forms. Signing below acknowledges notification of this.*****

I will continue billing Via: ☐ My old system ☐ Paper

Office Manager's Signature X _____

Test File Requirements:

1. A minimum submission of ten claims per tax identification number.
2. A sufficient claims sample reflective of routine billing.
3. If there are multiple providers within a group, claims from at least two providers are required.

*** Office Use Only ***

Sender ID: _____ Implementation Date: _____ Orientation Date: _____

Submission Method: ☐Web Upload ☐Dial FTP ☐Internet FTP

S:\EDI\FORMS\ANSI INTAKE FORM 9.28.09

Electronic Transaction Agent Designation Letter

Independent Health Association, Inc. Date: _____
Attn: e-Commerce Dept.
511 Farber Lakes
Buffalo, New York 14221

Dear Sir or Madam:

I, _____, authorize **ClaimRemedi** to
Authorized Agent for Covered Entity — Clearinghouse/Payment Processor
exchange electronic files and access electronic documents, as described

below, with Independent Health Association, Inc. for _____.
Covered Entity
I further certify that a valid Business Associates Agreement is in effect

between: (1) the **ClaimRemedi** and _____
Clearinghouse/Payment Processor — Covered Entity
and its subsidiaries and (2) _____ and _____.
Covered Entity — Authorized Agent for Covered Entity

We are requesting access to the following types of files to exchange and/or review:

- [x] 837 Electronic Claim Files and Response Files
- [x] 835 Electronic Remittance Advices
- [ ] Electronic Documents on Reveal (Requires Reveal Intake Form & User Agreement)

Sincerely,

_____ _____
Signature of Authorized Agent for Covered Entity — Date

_____ _____
Printed Name of Authorized Agent for Covered Entity — Tax ID

_____ **837P -jjg, 837I nrz**
Address — Submitter/Trading Partner ID

_____
City, State, Zip Code

_____
Telephone Number (including Area Code)

Please fax this letter to (716) 929-1062. No information will be released to the Clearinghouse/Payment Processor until a signed letter is returned to Independent Health.