EDI Claims Enrollment Form Instructions

Identification of Provider/Trading Partner and Transaction Information

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

Provider Information (All fields are required)	
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider.
Provider Federal Tax Identification Number (TIN)	Federal Tax Identification Number, also known as an Employer Identification Number (EIN), which identifies a business entity.
Doing Business As Name (DBA)	Registered business name; may be different than the official legal business/entity name.
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions. [From www.cms.gov]
Provider Address - Street	Number and street name where the provider or facility is located.
City	City associated with the provider address.
State/Province	ISO 3166-2 two-character code associated with the state/province/region of the applicable country.
ZIP Code/Postal Code	Postal-zone code; the ZIP ("Zone Improvement Plan") Code was introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.
Provider Contact Name	Name of a contact in the provider office for handling EDI issues.
Telephone Number	Phone number associated with the contact person.
Provider Email Address	Email address at which the Alliance might contact the provider for EDI issues.
Clearinghouse Information (Required field)	
Clearinghouse Name	Official name of the provider's chosen clearinghouse, which is a company that processes claims and sends them to payers, expediting reimbursement.
Submission Information (Required field)	
Reason for Submission	Select New Enrollment, Change Enrollment or Cancel Enrollment. Please explain the change to an existing enrollment.
Transmission Information (Select appropriate fields)	
Please specify which EDI transaction(s) you would like to setup with the Alliance. Select Professional (837 Professional Health Care Claim) and/or Institutional (837 Institutional Health Care Claim).	
Authorized Signature (Person submitting form)	
Name	Name of the person submitting the form.
Signature	Signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment.
Submission Date	Date on which the enrollment form is submitted.
Submitter Email Address	Email address at which the Alliance might contact the form submitter.