X12 HIPAA Standard Transaction Enrollment Request

Please complete this enrollment form to initiate your request to transmit data electronically with CDPHP®. To utilize the ASC X12 HIPAA standard file processing, you will need software or a practice management vendor or clearinghouse that can send, receive, and process compliant data files, with the ability to translate the data to your practice management systems. Please fax this form to **(518) 641-3301** or save it as a PDF and email to **EFAX_835@cdphp.com**.

To ensure your request is processed as quickly and efficiently as possible, please complete all sections below according to the transaction(s) you are requesting be implemented. For questions about this form or about connectivity, please contact the CDPHP Provider Relations team at 518-641-3890, or email E_Transaction_Help@cdphp.com.

Section I Enrollment Request

If you are not already set up to transmit and receive electronic data with CDPHP, select the "**New Enrollment**" option, along with the transaction(s) you are requesting be implemented. Otherwise, select "Change Enrollment" or "Cancel Enrollment" and specify the transaction(s) it applies to:

○ New Enrollment ○ Change Enrollment ○ Cancel Enrollment

○ 277CA Health Care Claims Acknowledgement

○ 837 Health Care Claim

○ 835 Health Care Claim Payment/Advice

Section II Provider Identification

Provider Name: ____________________

National Provider Identifier (NPI) #: ____________________ Tax Identification/EIN #: ____________________

Address 1: ____________________

City, State, Zip Code: ____________________

If your organization already has a CDPHP user ID (e.g., SFT0001), please indicate: ____________________

Section III Provider Business Office Contact Information

Business Contact Name: ____________________ Title: ____________________

Telephone: ____________________ Ext.: ________ Fax: ____________________

E-mail Address: ____________________

Section IV Technical Contact Information (if other than business contact)

Clearinghouse/Agent/Vendor Name: ____________________

Telephone: ____________________ Ext.: ________ Fax: ____________________

E-mail Address: ____________________

Which tax ID number will you be submitting under?: ____________________

Complete the following only if you will have a third-party vendor retrieving your 835 transactions from CDPHP:

Section V Authorization for Release of Information to Third-Party Vendor

I authorize ____________________ to act as my agent to view Capital District Physicians' Health Plan, Inc. (CDPHP), Capital District Physicians' Healthcare Network, Inc. (CDPHN), or CDPHP Universal Benefits, Inc. (CDPHP UBI) member data, including possible protected health information (PHI), in any format deemed appropriate by CDPHP, CDPHN, or CDPHP UBI, on my behalf. The entity listed above is my authorized business associate. I authorize the entity listed above to receive correspondence related to the submission and processing of ANSI X12 835 transactions on my behalf.

Signature: ____________________ Date: ____________________

Title: ____________________ Employer: ____________________