835 Electronic Remittance Advice (ERA) Enrollment Request

Please complete this form to initiate receipt of electronic claim remittance voucher statements from CDPHP® via the 835 transaction set and FAX to (518) 641-3301 or save as PDF and attach to email to EFax_835@cdphp.com. Large provider groups with multiple tax numbers and/or billing NPI numbers must complete a separate form for each tax/billing NPI combination.

Please contact your financial institution to arrange for the delivery of the CORE (Committee on Operating Rules for Information Exchange)-required Minimum CCD+(Corporate Credit or Debit entry) data elements needed for reassociation of the payment and the Electronic Remittance Advice (ERA).

Please direct questions about completing this form or matters concerning connectivity to the CDPHP Provider Relations team at **E_Transaction_Help@cdphp.com**.

Today's Date: _____

◯ **New Enrollment** ◯ **Change Enrollment** ◯ **Cancel Enrollment**

Section I Provider Identification

Provider Name: _____

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

Address 1: _____

Address 2: _____

City, State, Zip Code: _____

Section II Provider Business Office Contact Information

Business Contact Name: _____ Title: _____

Telephone: _____ Ext.: _____ Fax: _____

E-mail Address: _____

Section III Technical Contact Information (if applicable)

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:

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: _____