



EDI Claims Enrollment Form



Identification of Provider/Trading Partner and Transaction Information

All Trading Partners, whether covered entities or business associates of covered entities, agree to abide by all HIPAA privacy and security requirements as they apply to communications with the Alliance.

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

Provider Information (All fields are required)

Provider Name		Provider Federal Tax Identification Number (TIN)	
Doing Business As Name (DBA)		National Provider Identifier (NPI)	
Provider Address – Street	City	State/Province	ZIP Code/Postal Code
Provider Contact Name	Telephone Number	Provider Email Address	

Clearinghouse Information (Required field)

Please specify the clearinghouse you intend to use for electronic claims transmissions with the Alliance.	Clearinghouse Name
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Submission Information (Required field)

Reason for Submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment
Please describe the change:

Transmission Information (Select appropriate fields)

<input type="checkbox"/> Professional (837P) (ASC X12N 005010X222)	<input type="checkbox"/> Institutional (837I) (ASC X12N 005010X0223)
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Authorized Signature (Person submitting form)

Name	Signature	Submission Date	Submitter Email Address
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Please email completed form to edisupport@ccah-alliance.org or fax to 831-430-5895, ATTN: EDI Analyst.

NOTE: To enroll in Electronic Remittance Advice (ERA), complete the enrollment process at <https://enrollments.echohealthinc.com> or call ECHO Health Inc. at [888-834-3511](tel:888-834-3511).