Electronic Remittance Advice (835) Request Form

915.532.3778 ext. 1507 • Fax: 915.225.6762

BILLING PAY TO PROVIDER INFORMATION (PLEASE INCLUDE W9)

Official Business Name: _____

Doing Business As: _____

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

Federal Tax ID: _____ Group NPI: _____

Primary Contact: _____ Phone: _____ Email: _____

PROVIDER INFORMATION

Primary Service Location: _____

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

Phone: _____ Fax: _____ Website URL: _____

CLEARINGHOUSE INFORMATION

Clearinghouse Name: _____ Phone: _____

*Availity Customer ID# (**Genkey**): _____ Billing Submitter Number: _____

Software Vendor Name: _____ Phone: _____

***Genkey is required for Availity.**

AUTHORIZATION STATEMENT SIGNATURE

Provider *(enter provider/provider representative name)* _____ hereby appoints *(enter vendor name)* _____ to act as the authorized agent for the purpose of retrieving the 835 electronically from El Paso Health.

Provider/Provider Representative Signature: _____ Date: _____

EL PASO HEALTH PAYER IDs

El Paso First Health Plans Premier Plan STAR Medicaid HMO	Availity/ Trizetto Provider Solutions Payer ID: EPF02
El Paso First Health Plans CHIP	Availity/ Trizetto Provider Solutions Payer ID: EPF03
El Paso First Health Plan HCO Healthcare Options	Availity/ Trizetto Provider Solutions Payer ID: EPF37
Preferred Administrators	Availity/ Trizetto Provider Solutions Payer ID: EPF10
Preferred Administrators Children's Hospital	Availity/ Trizetto Provider Solutions Payer ID: EPF11
El Paso Health Medicare Advantage	Availity/ Trizetto Provider Solutions Payer ID: EPF07
El Paso First Health STAR+PLUS	Availity/ Trizetto Provider Solutions Payer ID: EPF02

CONFIRMATION OF TEST FILE

After submission of the Electronic Remittance Advice Request Form, a test file will be sent to ensure the successful transmission of the 835 file. Please enter the contact information for the representative that will be able to confirm receipt of the test file. Please note that the test file must be confirmed before the process can be completed. Failure to confirm the test file within 30 calendar days will cause the request to be closed and a new request will need to be submitted.

Contact Name: _____ Phone: _____ Email: _____