UNIVERSITY HEALTH ALLIANCE (UHA01)
PART B
EDI-ENROLLMENT INSTRUCTIONS

WHICH FORMS SHOULD I COMPLETE?

- EDI 837P Institutional Claim Registration Form (pages 2-3)
- ERA Request Form
  - *Complete only if you would like Office Ally to receive your ERAs.*

WHERE SHOULD I SEND THE FORM(S)?

- Email to hipaa-edi@uhahealth.com; OR
- Mail to:

  University Health Alliance (UHA)
  Attention: Information Services
  700 Bishop Street, Suite 300
  Honolulu, HI 96813

WHAT IS THE TURNAROUND TIME?

- Standard Processing Time is approximately 1 week.

HOW DO I CHECK STATUS?

- Once you receive confirmation that you've been linked to Office Ally, you may begin submitting your claims electronically.
- You can call UHA at (808) 535-5981 and ask for the status of your enrollment.

700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
T 808.532.4000
Toll-free 800.458.4600
www.uhahealth.com

EDI 837P PROFESSIONAL CLAIM REGISTRATION

The information provided on this EDI registration will be used to set up your office for electronic claims submission. **Please complete this form as accurately as possible**. If a section is not applicable, write "N/A." Please notify UHA of any changes to the information you have provided below.

UHA requires that all Providers read UHA's Trading Partner Agreement which can be found at:

https://uhahealth.com/uploads/forms/form_edi_trading_partner_agree.pdf

By signing this form, you acknowledge that you have read the Trading Partner Agreement and agree to its terms.

Mail, Fax or Email your completed form to: **UHA**
Attention: Information Services
700 Bishop Street, Suite 300
Honolulu, HI 96813
Email: hipaa-edi@uhahealth.com
Fax: 1-877-269-5568

Provider Identification Information: Federal Tax ID _____ / Organization (Type2) NPI (if applicable): _____

Please list all Providers, along with their individual (Type1) NPI's that apply to the above Organization, if applicable.

Provider Name:	**Individual (Type1) NPI:**

For additional Providers, please attach a separate list

Provider Demographic Information:

Name: _____

Complete legal name of institution, corporate entity, practice or individual provider

Mailing Address: _____ City: _____ State: ____ Zip Code: _____

Physical Address: _____ City: _____ State: ____ Zip Code: _____

Contact: _____ Telephone: _____ Fax: _____

Email: _____

Clearinghouse Information

Name: Office Ally

Mailing Address: PO Box 872020 City: Vancouver State: WA Zip Code: 98687

Physical Address: 1300 SE Cardinal Court Ste 190 City: Vancouver State: WA Zip Code: 98683

Contact: Payer Enrollment Dept Telephone: 360-975-7000 opt 1 Fax: 360-896-2151

Email: PayerEnrollment@OfficeAlly.com

If you wish to receive your remittance advice (835) electronically, then please fill out and complete the ERA Request Form.

I authorize the setup and/or change noted above for the EDI 837P transaction.

_____ _____ _____

Print Name Signature Date

_____

Title

To be completed by UHA

Transmitter ID: _____

Submitter ID: _____