VA Premier CompleteCare
a Commonwealth Coordinated Care Plan

EDI 837 Claims Enrollment Form

(To Send Electronic Claims to VPHP)

Date

1 | Submitter Information *(to be filled out by the clearinghouse)*	
CLEARINGHOUSE	**Availity**
Clearinghouse Contact Name: **Customer Service**	
Clearinghouse Address **P.O. Box 550857**	
City **Jacksonville**	State **FL** Zip **32255**
Phone **800-282-4548**	Email **support@availity.com**
[Note: VPHP will send enrollment confirmation to the email address above.]	
2 | Billing Agent/Service Information *[refers to the clearinghouse]*	
Billing Agent Tax ID **593715944**	
3 | Provider Group Information **(W-9 Required)**	
Group Name	
Group Tax ID	
Group NPI # *(if applicable)*	
4 | Provider Remittance/Billing Address	
Address	
City	State Zip

Internal Use

ID#____________
____

W-9 on file______

Database ☐
FAX ☐
E-Mail ☐
Date ____________

PROVIDER NAME **(Including TITLE)** (e.g. MD, DO, DPM)	**PROVIDER SPECIALTY** (e.g. Family Practice)	**PROVIDER NPI # (10 Digits)**	**PROVIDER TAXONOMY CODE**	**PAR** (Participating) Or **Non-Par**

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Please complete and return via email to vpccfaxpdt@vapremier.com

If you are unable to email this form, please fax it to **877-739-1367**

A copy of your **W-9** is required when completing EDI enrollment

Enrollment will take approximately 10 business days