Please complete and return via email to vphp_edi@vapremier.com
If you are unable to email this form, please fax it to 877-289-9340

EDI 837 Claims Enrollment Form
(To Send Electronic Claims to VPHP)

Date

1 | *Submitter Information* *(to be filled out by the clearinghouse)*	
CLEARINGHOUSE	
Clearinghouse Contact Name	
Email	
[Note: VPHP will send enrollment confirmation to the email address above.]	
& | *Provider Group Information* ***(W-9 Required)***	
Group/Provider Name	
Group/Provider Tax ID	
Group/Provider NPI# (if applicable)	
' | *Group/Provider Remittance/Billing Address*	
Address	
City State Zip	

Provider Name **(including TITLE)** (eg MD, DO, DPM)	**Provider Specialty** (eg Family Practice)	**Provider NPI #** **(10 Digits)**	**Provider Taxonomy Code**	**PAR** (Participating) OR **Non-Par**

Revised 07/31/13

VA Premier
Health Plan, Inc.

Provider Name **(including TITLE)** (eg MD, DO, DPM)	**Provider Specialty** (eg Family Practice)	**Provider NPI # (10 Digits)**	**Provider Taxonomy Code**	**PAR** (Participating) OR **Non-Par**

- *If your clearinghouse instructs you to send this form directly to VPHP, either:*
  - *[Preferred]*
    Email the completed form (as an attachment) to: ***vphp_edi@vapremier.com***

  - Or –
  - *Fax the completed form to:* ***877-289-9340***

- *Confirmation of your EDI Enrollment at VPHP will be emailed within ten business days.*