# AMERICAN SPECIALTY HEALTH (ASHP1)
# 835 ENROLLMENT REQUEST

Email this form to support@officeally.com or Fax to (360) 896-2151. Please make sure to print legibly and to complete this form in its entirety. You risk delaying enrollment if the application is unreadable or incomplete.

## PROVIDER INFORMATION

**Provider Name:**

**Provider Address:** **City:** **State:** **Zip:**

## PROVIDER IDENTIFIERS INFORMATION

**Provider Federal Tax Identification Number**
**Employer Identification Number (EIN):**

**National Provider Identifier (NPI):**

## PROVIDER CONTACT INFORMATION

**Contact Name:** **Telephone Number/Extension:**

**Email Address:** Fax Number:

## ELECTRONIC REMITTANCE ADVICE INFORMATION (CHECK ONLY ONE)

**Preference for Aggregation of Remittance Data:** (i.e. Account Number Linkage to Provider Identifier). Note: Provider Preference for grouping (bulking) claim payment advice. Must match preference for EFT payment (i.e. Billing Provider). Choose and fill in only **one**.

☐ Provider Federal Tax Identification Number (TIN):

☐ National Provider Identifier (NPI):

## SUBMISSION INFORMATION

**Reason for Submission:** New ERA Enrollment

**Authorized Signature:**

Submit by Email

Note: Electronic Signature (Typed Name) of Person Submitting ERA Enrollment.