WHICH FORMS SHOULD I COMPLETE?

- **<u>Capital District Physicians' Health Plan (CDPHP) Professional Remit Information Sheet</u>** (Pg. 2)
  - o Complete with your group/billing information. **DO NOT** complete for individual providers who bill under the group.
- **<u>835 Electronic Remittance Advice (ERA) Enrollment Request</u>** (Pg. 3)
  - o Select "New Enrollment" if provider has never been enrolled for ERAs with this payer, or "Change Enrollment" if currently receiving ERAs and requesting to change the clearinghouse vendor to Veradigm (our trading partner).
  - o Complete Sections I and II with Group/Billing Provider Information. **DO NOT** complete for individual providers who bill under the group.
  - o Signature required by the provider or authorized representative of the group. **Billing Services cannot sign.**

WHERE SHOULD I SEND THE FORM(S)?

- Fax both forms to Veradigm at (919) 800-6875
  - o Please do not forward the enrollment directly to the Payer as this will result in delay of the remit setup.

WHAT IS THE TURNAROUND TIME?

- Standard processing time is 5-10 business days

HOW DO I CHECK STATUS?

- You can call CDPHP at (518) 641-3805 to check enrollment status.

Capital District Physicians' Health Plan (CD PHP) Professional Remit Information Sheet

* ALL fields of this form must be completed in order to be set up properly for CD PHP remit.

Allscripts Client ID:	BSG5890
Organization Name:	
Tax ID:	
NPI Number:	
Address:	
City, State, Zip:	
Contact Name:	
Contact Phone:	
Contact Email:	

Fax completed form to Allscripts Clearinghouse Partner Enrollment @ (919) 800-6875.

835 Electronic Remittance Advice (ERA) Enrollment Request

Please complete this form to initiate receipt of electronic claim remittance voucher statements from CDPHP® via the 835 transaction set and **FAX to (518) 641-3301** or save as PDF and attach to email to **EFax_835@cdphp.com**. Large provider groups with multiple tax numbers and/or billing NPI numbers must complete a separate form for each tax/billing NPI combination.

Please direct questions about completing this form or matters concerning connectivity to the CDPHP Provider Relations team at **E_Transaction_Help@cdphp.com**.

Today's Date: _____

◯ **New Enrollment**   ◯ **Change Enrollment**   ◯ **Cancel Enrollment**

Section I Provider Identification

Provider Name: _____

National Provider Identifier (NPI) #: _____   Tax Identification/EIN #: _____

Address 1: _____

Address 2: _____

City, State, Zip Code: _____

Section II Provider Business Office Contact Information

Business Contact Name: _____   Title: _____

Telephone: _____   Ext.: _____   Fax: _____

E-mail Address: _____

Section III Technical Contact Information (if applicable)

Clearinghouse/Agent/Vendor Name: _____

Telephone: _____   Ext.: _____

E-mail Address: _____

Which tax ID number will you be submitting under?: _____

Complete the following only if you will have a third-party vendor retrieving your 835 transactions from CDPHP:

I authorize _____ to act as my agent to view Capital District Physicians' Health Plan, Inc. (CDPHP), Capital District Physicians' Healthcare Network, Inc. (CDPHN), or CDPHP Universal Benefits, Inc. (CDPHP UBI) member data, including possible protected health information (PHI), in any format deemed appropriate by CDPHP, CDPHN, or CDPHP UBI, on my behalf. The entity listed above is my authorized business associate. I authorize the entity listed above to receive correspondence related to the submission and processing of ANSI X12 835 transactions on my behalf.

Signature: _____   Date: _____

Title: _____   Employer: _____