



835 EDI ENROLLMENT FORM

Healthcare providers who are interested in receiving 835s from the US Family Health for Texas and Louisiana must complete the attached application and follow the directions as set forth below.

Please note: In order to be enrolled to receive 835s from the US Family Health Plan in Houston, a healthcare provider must have provided services to a US Family Health Plan member who resides either in the state of Texas or Louisiana.

Providers will not be added into the Plan's system if they have not provided services to a US Family Health Plan member residing in either Texas or Louisiana. If a provider has seen a US Family Health Plan member from another region (i.e., New York, Maine, etc.), the provider needs to contact and register with the US Family Health Plan for that region. Information regarding each region can be found at www.usfhp.com.

Please follow the directions below:

1. Please complete the attached form. Section I should include information at the highest level for the provider. Section II should include all providers for which a claim will be submitted. For example, physician groups should include information regarding the group in Section I and then include all the individual physicians included in the group in Section II. Healthcare providers include solo practitioners, allied healthcare professionals, groups, facilities and ancillary providers.

Please Note: If you are a solo practitioner or an individual provider, you only need to complete Section I.

2. Once the attached form is completed, please forward the form and a copy of your current 2011 **W-9** to US Family Health Plan either via fax to **281-936-7915** or it can be sent via e-mail to **USFHPEDI@usfhpchristus.org**
3. Once the EDI Form and your current 2011 W-9 are received by the US Family Health Plan and you, the provider, have been set up in the Plan's system, the Plan will notify your clearinghouse/billing service via e-mail that you are ready to begin receiving 835 transactions with our Plan.
4. Should you or your clearinghouse/billing service have any questions regarding the above process, you can contact the US Family Health Plan's EDI Specialist at 281-936-7095 or via e-mail at USFHPEDI@usfhpchristus.org.

Section I

Date:	<input type="checkbox"/> MD	<input type="checkbox"/> DO	<input type="checkbox"/> DPM	<input type="checkbox"/> Other:
Which form do you use to submit claims?	<input type="checkbox"/> HCFA-1500		<input type="checkbox"/> UB-04	
Provider/Facility Name:				
Provider Address :				
Provider City/State/Zip:				
Business Name as indicated on current 2011 W-9:				
Provider Tax Identification Number (TIN):		NPI 1 (if applicable):		NPI 2 (if applicable):
Provider Office's Contact Name:			Phone Number for Office Contact:	
Provider E-mail Address:				
Billing Service/Clearinghouse Name:	Office Ally			
Billing Service/ Clearinghouse Contact Name:	Customer Service	Billing Service/Clearinghouse Phone Number:	360-975-7000 Option 1	
Billing Service/ Clearinghouse E-Mail Address:	support@officeally.com			
Availity Customer ID : (Required)	11904			

Section II

Please list each individual provider's name and their corresponding NPI 1 or NPI 2 in the space provided below.
(If necessary, please continue list on a separate piece of paper).

Provider Name	NPI

For Office USFHP Use Only

- INN ONN
- Network/Region**
- ALL CYPR STCA STJN STJO
- SETX SGLN MMCN WLBN LALC

Network Representative

- V, Melancon E.DeMien M. Harris
- E.Howard-Provost K.Pace

Contact Validation _____

Contact Phone Number _____

Validation Date _____

Notes: _____

Date given to EDI Specialist: _____

Signature: _____

Date: _____