

CAREPARTNERS OF CT (16307) EDI ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- Emdeon EDI Enrollment Form
- CarePartners of Connecticut EDI Set-Up

WHERE SHOULD I SEND THE FORM(S)?

- Email the Change Healthcare EDI Enrollment form to batchenrollment@changehealthcare.com
- Email the CarePartners EDI Set-Up form to EDI CT Operations@carepartnersct.com

WHAT IS THE TURNAROUND TIME?

Turn-around time is approximately 10 days.

Office Ally, Inc | PO Box 872020 | Vancouver, WA 98687 | (360) 975-7000

				Payer Inf	ormation					
CPID	Payer	r ID	Payer			Туре	9	Est Days	Multi CH	
Special Enrollment Instructions										
				Vendor In	formation					
Submitte	er ID	Submitter Name								
Provider Information										
Tax ID		NPI		Provider Number	Name					
Address					City			State	Zip	
Contact Name								Contact	Phone	
Contact	Contact Email Address									
				Confirmatio						
Primary	Addre	SS		Secondary Email Address						
Report Method										
TSO ID		Repo	rt Type	Communication Pro	tocol/Output Report		Report Fo	rmat	Site ID	



EDI Set-Up Form

Completed forms can be sent to EDI_CT_Operations@carepartnersct.com or faxed to 617-972-1011. EDI Operations will contact you after this information is verified to initiate electronic transactions. Please contact EDI Operations at 888-631-7002, ext. 52994 if you have any questions regarding this form.

PRACTICE , ACCOUNT AND TRANSACTION INFORMATION									
FRACTICE, ACC	OONT AND TRAN	SACTION INFOR	WATION						
Practice Type:	Solo	Group	☐ Billing Service	☐ Hospital/Facility					
Type of account:	New	Existing (indi	icate changes below)						
Transaction Type:	837 Institutio	nal claim 🔲 83	37 Professional claim						
INFORMATION	ON SOLO, GROUP	, BILLING SERVIC	E CLIENT(S), HOSPITAL/F	ACILITY					
Name:									
Address:									
City:			State:	ZIP code:					
Office contact:			Practice Tax II	Practice Tax ID:					
Telephone:			Fax:	Fax:					
Email Address:									
Practice Management System/Computer Vendor:									
Vendor Contact	: Name:		Teleph	Telephone:					
PAYMENT INFO	RMATION (IF DIF	FERENT FROM AB	BOVE)						
Name of payees	:		Nation	National Provider ID:					
Address:									
City:			State:	ZIP code:					
Payee tax ID:									
PROVIDER INFORMATION									
Name of Provide	r		National Provider ID	National Provider ID					
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