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.

Send completed form to:
Batchenrollment@changehealthcare.com
Fax: (615) 885-3713

CHANGE HEALTHCARE

Claims

Payer Information

CPID	Payer ID	Payer	Type	Est Days	Multi CH
8170	16307	CAREPARTNERS of CONNECTICUT	Professional	10	No

Special Enrollment Instructions

Vendor Information

Submitter ID	Submitter Name
330897513	OFFICE ALLY

Provider Information

Tax ID	NPI	Provider Number	Name

Address	City	State	Zip

Contact Name	Contact Phone

Contact Email Address

Confirmation Addresses

Primary Email Address	Secondary Email Address

Report Method

TSO ID	Report Type	Communication Protocol/Output	Report Format	Site ID
F042	N	K	L	0000

For Change Healthcare use only

CarePartners of Connecticut

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

Practice Type: ☐ Solo ☐ Group ☐ Billing Service ☐ Hospital/Facility

Type of account: ☐ New ☐ Existing (indicate changes below)

Transaction Type: ☐ 837 Institutional claim ☒ 837 Professional claim

INFORMATION ON SOLO, GROUP, BILLING SERVICE CLIENT(S), HOSPITAL/FACILITY

Name: _____

Address: _____

City: _____ State: Off ZIP code: _____

Office contact: _____ Practice Tax ID: _____

Telephone: _____ Fax: _____

Email Address: _____

Practice Management System/Computer Vendor:

Vendor Contact Name: _____ Telephone: _____

PAYMENT INFORMATION (IF DIFFERENT FROM ABOVE)

Name of payee: _____ National Provider ID: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Payee tax ID: _____

PROVIDER INFORMATION

Name of Provider	National Provider ID

Email