MMM HEALTHCARE (L0210)
EDI-ENROLLMENT INSTRUCTIONS

WHICH FORMS SHOULD I COMPLETE?

- Change Healthcare EDI Enrollment Form
- Assertus Provider Enrollment Form

WHERE SHOULD I SEND THE FORM(S)?

- Email the **Change Healthcare EDI Enrollment form along with the Assertus Provider Enrollment form** to batchenrollment@changehealthcare.com

WHAT IS THE TURNAROUND TIME?

- Standard Processing Time is approximately 14 days.

HOW DO I CHECK STATUS?

- Once you receive confirmation that you've been linked to Office Ally, you MUST call (360-975-7000) or email Support@officeally.com with the below information PRIOR to submitting claims electronically. Failure to do so will result in claim rejections.

  Email Subject: MMM Healthcare (L0210) – EDI Approval

  Body of Email:

  Please log my EDI approval for First Medical Health Plan

  - Provider Name:
  - NPI:
  - Tax ID:

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
1591	L0210	Medicare y Mucho Mas (MMM)	Institutional	14	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

 Last Revised Date: 05/13/22

assertus®
YOUR HEALTHCARE TECHNOLOGY PARTNER

PROVIDER ENROLLMENT
TRANSMISSION AUTHORIZATION

By completing and signing this authorization, the healthcare Provider is authorizing Assertus Holdings, LLC to interchange its electronic Healthcare transactions with the Trading Partner acting as a Delegate Transmission Site for the Healthcare Provider as reported hereunder.

Delegate Transmission Site	Site Account Number	NPI
CHC1	581651222	
Provider Name	Phone	Fax
Type ☐ Solo Practitioner ☐ Group Practice	Email	
Street Address	Postal Address ☐ Same as Street Address	
Off		

Notes:

Authorization

Hereby, I certify that I'm the Provider referenced above or an authorized representative and that the reported NPI on this form belongs to the Provider referenced above, and I authorize ASSERTUS Holdings, LLC for the interchange of related health care transactions thru the Delegate Transmission Site reported on this form. I understand that this authorization will remain active until canceled in writing. I also understand that it is my responsibility to monitor that every claims file submitted to Assertus has a positive confirmation receipt received and that I need to report to Assertus any missing confirmation receipts.

Billing Provider Authorized Signature	Date:	ASSERTUS Authorized Signature	Date:
Complete agreement, print, and obtain signature.			