# 835 ENROLLMENT REQUEST

## ViCare Health IPA - VCH01

Email this completed form to edisupport@allcaretoyou.com. Please make sure to print legibly and to complete this form in its entirety. You risk delaying enrollment if the application is unreadable or incomplete.

### Provider Information

**Provider Name:**

**Provider Address:**

### Provider Identifier Information

**Provider Federal Tax Identification Number (TIN) OR Employer Identification Number (EIN):**

**National Provider Identifier (NPI):**

### Provider Identifier Information

**Provider Contact Name:**

**Telephone Number:** **Fax Number:**

**Email Address:**

### Electronic Remittance Advice Information

**Preference for Aggregation Of Remittance Data:**

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***Note:*** *Account Number Linkage to Provider Identifier. Must match preference for EFT payments.*

### Electronic Remittance Advice Information

Reason for Submission: Cancel ERA Enrollment

Authorized Signature:

***Note:*** *Electronic Signature (typed name) of Person Submitting ERA Enrollment.*