BILLING AND EDI
AUTHORIZATION AND SET UP FORM

The Health Plan – EDI Support Center

1110 Main St
Wheeling, WV 26003

P: 800.624.6961 Ext 6248
740.699.6248

Email: hpecs@healthplan.org

The Health Plan requests the completion of this form to insure proper release of information to further protect your patient's healthcare information. This form is to be completed by the Practice/Group representative to provide the necessary information to The Health Plan for communication purposes.

In the majority of cases, healthcare providers/facilities, utilize outside vendors/billing companies/clearinghouses to assist in the processing of healthcare claims and payments. We are requesting notification who these outside vendors/companies/clearinghouses are representing your office/organization prior to releasing any HIPAA Protected Health Information.

This information should be kept current by completing another form to reflect these changes.

Below is a reference guide:

- Please include both the individual provider NPI and group NPI if applicable.
- Use one enrollment form per tax ID.
- Please provide effective date of any updates.

Return completed form to the above address or email addresses. Allow 5-10 business days for processing. Processing times may vary based on volume received by The Health Plan.

Questions Contact: Provider Relations or Email agummer@healthplan.org or Fax 740.699.6169

TYPE OF REQUEST: ☐ Initial ☐ Change ☐ Delete EFFECTIVE DATE:

PROVIDER NAME: PROVIDER OR FACILTY (CIRCLE ONE OR BOTH)	PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI):	
FEDERAL TAX IDENTIFICATION NUMBER: ___ ___ ___ ___ ___ ___ ___ ___ ___	GROUP NATIONAL PROVIDER IDENTIFIER (NPI):	
PROVIDER ADDRESS:		
PROVIDER TELEPHONE #:	PROVIDER FAX #:	
GROUP NAME (if applicable):		
CONTACT:	TELEPHONE #:	EMAIL:
REMIT ADDRESS:		
TELEPHONE #:	FAX #:	EMAIL:
OUTSIDE BILLING SERVICE NAME (if applicable):		
BILLING SERVICE ADDRESS:		
BILLING SERVICE CONTACT:	TELEPHONE #:	EMAIL:

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VENDOR / CLEARINGHOUSE FOR ELECTRONIC FILINGS (Place name under category)				
ELECTRONIC CLAIMS 837	ELECTRONIC VOUCHERS ERA/835	ELIGIBILITY FILINGS 270	CLAIM STATUS 276	AUTHORIZATION REQUEST/RESPONSE 278

CONTACT:	TELEPHONE #:	EMAIL:

DIRECT DEPOSIT: ☐ Yes ☐ No EFFECTIVE DATE:

BANK NAME:

BANK ADDRESS:

BANK ROUTING NUMBER (9 digits; on check, not deposit slip): ___ ___ ___ ___ ___ ___ ___ ___ ___

BANK ACCOUNT #: ☐ CHECKING ☐ SAVINGS

**PLEASE PROVIDER A PRE-PRINTED VOIDED CHECK OR BANK LETTER.

AUTHORIZATION AGREEMENT – PLEASE READ AND SIGN BELOW.
REQUIRES SIGNATURE OF PROVIDER / OWNER / GROUP REPRESENTATIVE.

Electronic Funds Transfers (EFT)

This authorizes The Health Plan, to initiate credit entries to the account at the bank listed on this form for all benefit payments. This agreement will remain in effect until I notify The Health Plan of the cancelation or modification or until I am no longer active in the Health Plan's system. I authorize and request the bank listed to accept any credit entries by the Health Plan to the account listed. The Health Plan will not debit or deduct funds directly from the bank account for claim overpayments and/or refund requests.

Electronic Remittance Advice (ERA)

The Health Plan will transmit the claims payments in our HIPAA-compliant ERA transactions format.

AUTHORIZING NAME (PLEASE PRINT):	TITLE:
AUTHORIZING SIGNATURE:	DATE: