

837 EDI Intake Form

To enroll for EDI
 To change EDI channel
 To add providers

Date of Submission _____	Billing Address _____
Effective Date of Change _____	City/State/Zip _____
Organization _____	Tax ID # _____
Contact(s) _____	NPI # _____
Title _____	E-mail _____
Physical Address _____	Phone _____
City/State/Zip _____	Fax _____

Do you use a Clearinghouse? Yes No If so, whom do you use? _____

What type of claims will you be sending? (Check all that apply) Institutional Professional

If billing direct 837 submissions:

- What is the name of the practice management or billing system? _____
- Version? _____

Is your system HIPAA-compliant? Yes No

How do you currently submit claims to Scott & White Health Plan? Paper EDI

Do you use a billing service and/or an intermediary? Yes No

If yes, who do you use? _____

Please identify your IT resources available to support your testing and transaction submission:

Internal Name _____ Phone _____ Email _____

Vendor/billing agency contact Name _____ Phone _____ Email _____

Please use additional spreadsheet(s) as necessary.

Provider Name	Provider Specialty	Provider NPI #	Group Payee NPI #	Tax ID #

Please fax to **1-254-298-6019**.

Notification of completed request will be processed via return fax.