Print Form

UHA HEALTH INSURANCE

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EDI 837I INSTITUTIONAL CLAIM REGISTRATION

The information provided on this EDI registration will be used to set up your office for electronic claims submission. **Please complete this form as accurately as possible**. If a section is not applicable, write "N/A." Please notify UHA of any changes to the information you have provided below.

UHA requires that all Providers read UHA's Trading Partner Agreement which can be found at:

uhahealth.com/uploads/forms/form_edi_trading_partner_agree.pdf

By signing this form, you acknowledge that you have read the Trading Partner Agreement and agree to its terms.

Mail, Fax or Email your completed form to: **UHA**
Attention: Information Services
700 Bishop Street, Suite 300
Honolulu, HI 96813
Email: hipaa-edi@uhahealth.com
Fax: 1-877-269-5568

Facility Identification Information: Federal Tax ID / NPI: _____ / _____

Facility Information:

Name: _____

Mailing Address: _____ City: _____ State: ____ Zip Code: _____

Physical Address: _____ City: _____ State: ____ Zip Code: _____

Contact: _____ Telephone: _____ Fax: _____

Email:_____

Clearinghouse Information:

Name: _____

Mailing Address: _____ City: _____ State: ____ Zip Code:_____

Physical Address: _____ City: _____State: ____ Zip Code: _____

Contact: _____ Telephone: _____ Fax: _____

Email: _____

If you wish to receive your remittance advice (835) electronically, then please fill out and complete the ERA Request Form.

(Continued on next page)

I authorize the setup and/or change noted above for the EDI 837I transaction.

Print Name	Signature	Date

Title

To be completed by UHA

Transmitter ID:_____

Submitter ID:_____