Print Form

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EDI 837P PROFESSIONAL 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

Provider Identification Information: Federal Tax ID_____ / Organization (Type2) NPI (if applicable): _____

Please list all Providers, along with their individual (Type1) NPI's that apply to the above Organization, if applicable.

Provider Name:	**Individual (Type1) NPI:**

For additional Providers, please attach a separate list

(Continued on next page)

Provider Demographic Information:

Name: _____
Complete legal name of institution, corporate entity, practice or individual provider

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.

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

_____ _____ _____
Print Name Signature Date

_____
Title

To be completed by UHA

Transmitter ID:_____

Submitter ID:_____