Print Form

UHA HEALTH INSURANCE

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ERA REQUEST FORM

The information provided on this form will be used to set up your office for Electronic Remittance Advice (ERA). **Please complete this form as accurately as possible**. If a section is not applicable, write "N/A."

In order to receive an Electronic Remittance Advice (ERA), you must be enrolled for electronic claims submission.

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

I. Provider Information

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

Provider Address:

Street: _____

City: _____

State/Province: _____

ZIP Code/Postal Code: _____

II. Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

_____

National Provider Identifier (NPI) _____

III. Provider Contact Information

Provider Contact Name: Contact: _____

Telephone Number: _____

Email Address: _____

Fax Number: _____

(Continued on next page)

IV. Electronic Remittance Advice Information

If you want to receive an Electronic Remittance Advice (ERA), then please complete this section.

Provider Tax Identification Number (TIN): _____

National Provider Identifier (NPI) _____

V. Electronic Remittance Advice Clearinghouse Information

If you want to receive an Electronic Remittance Advice (ERA) through your Clearinghouse, then please complete this section.

Clearinghouse Name: _____

Clearinghouse Contact Name: _____

Telephone Number: _____

Email Address: _____

VI. Submission Information

Reason for Submission: _____

Authorized Signature: _____

Printed Name of Person Submitting Enrollment: _____