



Partnership HealthPlan of California

835 ERA Enrollment & Payer Agreement

The **835 ERA Enrollment & Payer Agreement Document** should be completed and signed by the Trading Partner and the Pay-To Provider. The Trading Partner must have an active EDI connection with PHC and must have a completed 835 ERA EDI enrollment form on file with PHC. The Trading Partner and the Pay-To Provider representatives that sign the **835 ERA Enrollment & Payer Agreement Document** indicate that the Trading Partner is authorized to receive the requested 835 ERA files on behalf of the Pay-To Provider.

835 Electronic Remittance Advice files

An ERA is an electronic version of a remittance advice. It details how claims were paid or why they were denied. Partnership HealthPlan of California utilizes the standard HIPAA compliant ANSI X12 5010 version of 835 formats for creating ERA files. Computer software might be needed to translate the 835 file's information. Many clearinghouses translate the 835 file format for their customers. Some providers utilize practice management software to translate the 835 file format.

The completed **835 ERA Enrollment & Payer Agreement Document** should be
faxed to **707-863-4390** or
emailed to: **EDI-Enrollment-Testing@partnershiphp.org**

After the **835 ERA Enrollment & Payer Agreement Document** is processed, our EDI Team will send an email notification to the Trading Partner and the Pay-To provider regarding enrollment completion.

It is important to remember that once a provider has enrolled for 835 files, PHC no longer sends a paper copy of the remittance advice with payment. Enrollees should utilize the information that is provided in their electronic remittance advice (835 file).



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EDI PAYER AGREEMENT

This Electronic Data Interchange (EDI) Payer Service Agreement (the “**Agreement**”) is entered into by and between Partnership HealthPlan of California, a California corporation, with a principal place of business at 4665 Business Center Drive, Fairfield, California 94534 (hereinafter, “**PHC**”), and _____ (hereinafter, “**Trading Partner**”). The purpose of this Agreement is to memorialize in writing, the existing connection PHC has with the Trading Partner to submit and receive EDI transactions on behalf of the Provider named in this agreement. In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, PHC must have Business Associate Agreements in place to assure compliance with the rules and regulations dictated by it.

TRADING PARTNER’S (RECEIVER) INFORMATION

Trading Partner’s Full Legal Name:

Trading Partner’s Principal Business Address:

Trading Partner’s Mailing Address (if different from principal business address above):

Trading Partner’s Tax ID #: _____

Trading Partner’s State of Incorporation: _____

Trading Partner’s Contact Person:

Trading Partner’s Telephone Number:

Trading Partner’s E-Mail Address:

Trading Partner’s Fax Number:

PAY-TO PROVIDER’S INFORMATION

Pay-To Provider’s Name:

Pay-To Provider’s Pay-To NPI Number:

Pay-To Provider’s Contact Person:

Pay-To Provider’s Tax ID (ETIN):

Pay-To Provider’s Telephone Number:

Pay-To Provider’s Email Address:

Pay-To Provider’s Physical Address:



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REQUEST TO ENROLL FOR 835 ERA FILES

Trading Partner requests the following outbound transactions from PHC.

835 Electronic Remittance Advices

An 835 file is an electronic version of a remittance advice. Software is needed to translate the 835 file's information. A copy of Partnership HealthPlan's 835 crosswalks for adjustment reason codes, remittance advice remark codes and explanation codes can be found on PHC's website at http://www.partnershiphp.org/Provider/EDI_Pubs.htm.

It is important to remember that once a provider has enrolled for 835 files, PHC no longer sends a paper copy of the remittance advice with payment.

PAY-TO PROVIDER AND TRADING PARTNER (RECEIVER) CONFIRMATION

The representative that signs this document on behalf of the Pay-To Provider and Trading Partner indicates that they are authorized to request claim transactions on behalf of the Provider named in this agreement.

On behalf of **Pay-To Provider**

On behalf of **Trading Partner**

Signature of authorized representative

Signature of authorized representative

Printed Name

Printed Name

Title

Title

Date

Date

Please return this form to our EDI Team by faxing or emailing a copy to:

E-Mail: EDI-Enrollment-Testing@partnershiphp.org

Fax: 707-863-4390

To inquire about this form, please call 707-863-4527