Provider/Group Access Information for 837 Transaction Set

To request initial set-up or to make changes for electronic claim submissions to CDPHP® via the HIPAA 837 standard transaction set, please complete this form for each provider in your office or group and **fax it to (518) 641-3302**.

For questions about completing this form or for matters concerning connectivity, please contact the CDPHP Provider Relations team at **(518) 641-4334, or EDI_Team@cdphp.com**.

You must have software, a practice management vendor, or clearinghouse that can send a compliant file directly to CDPHP, with the ability to translate the file to your practice management accounts receivable system.

CDPHP Provider #: _____

If your organization already has a CDPHP user ID (e.g., SFT0001) please indicate: _____

Section I: Provider/Group Identification

*This information must match with what is on CDPHP systems. (*Required fields.)*

*Business Name: _____

*Tax ID#: _____

Current Paper Check Remit Address:

Address: _____

Address: _____

City, State, ZIP: _____

Section II: Provider Business Office Contact Information

Business Contact Name: _____ Title: _____

Telephone: _____ Ext.: _____ Fax: _____

Email Address: _____

Section III: Technical Contact Information (Vendor or IT Dept.) *(If other than business contact)*

Technical Contact Name: _____ Title: _____

Telephone: _____ Ext.: _____ Fax: _____

Email Address: _____

Print Name: _____

Signature: _____ Date: _____