



Capario EDI  
1901 E. Alton Ave. #100  
Santa Ana, CA. 92705  
Phone: (800) 792-5256 Option 1  
Fax: (404) 877- 3324  
provider.enrollment@Capario.com

## Payer Agreement Instructions for Independent Health (95308)

To enroll with this payer complete and send the payer agreement directly to Independent Health. In addition please complete and send the Capario Provider Enrollment Form to our EDI Team. Specific instructions for this Payer are shown below.

If you are a Capario customer then complete the Payer enrollment process BEFORE submitting claims to Capario for this Payer.

If you are not yet a Capario customer please contact Capario sales at: [ProviderSales@Capario.com](mailto:ProviderSales@Capario.com) or 800-586-6870.

### Guidelines for Enrolling with this Payer

**\*\*NOTE\*\*** Independent Health requires enrollment AND end-to-end Provider-to-Payer testing for each billing provider requesting approval to send claims.

#### To Enroll:

**1. Fax the Independent Health Electronic Claims Sender Request Form to:**

Independent Health

**Fax:** (716) 929-1062

- Independent Health will process your form within 3-5 business days and issue you a 3 alpha submitter ID. They will send this ID via secure email to Capario.

#### To Test:

- A Capario representative will contact you after we receive confirmation from the payer that they are ready to start testing.
- For testing you will need at least 15 to 20 claims.
- As soon as the test results with Independent Health are successful the payer will approve you for production.
- Please DO NOT send claims to production until you have been approved. Sending claims before you are approved will result in rejections.

**2. Mail, Fax or Email the Capario Provider Enrollment Form to:**

Capario

EDI Team

1901 E. Alton Ave. Suite 100

Santa Ana, CA. 92705

**Fax:** (404) 877-3324

Email: [provider.enrollment@Capario.com](mailto:provider.enrollment@Capario.com)

To obtain the Capario Provider Enrollment Form, go to:

[www.capario.com/services/resource\\_center/enrollment\\_instructions.html](http://www.capario.com/services/resource_center/enrollment_instructions.html)

*Questions? Contact Capario Enrollment at: (800) 792-5256 Option 1*



### Electronic Claims Sender Request Form

Please fax the completed form to (716) 929-1062. Please contact the E-Commerce call center at (716) 635-3911 if you have any questions.

**Please indicate reason for test submission:**

New EDI Submitter  Software Vendor Change  Other: \_\_\_\_\_

**Please indicate payer(s) you will be submitting for:**

Independent Health  Nova

**Please indicate the transaction(s) you would like to exchange:**

ANSI 837 Institutional  ANSI 837 Professional  ANSI 837 Dental ANSI  835 Remittance

Date of Request: \_\_\_\_\_ Office Practice Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Office Contact Person: \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Office Tax Identification Number: \_\_\_\_\_

Multiple Offices with same Tax Identification Number:  Yes  No

Multiple Offices with multiple Sender Id's:  Yes  No

NPI Numbers: \_\_\_\_\_

Your Office is:  Par  Non-Par Your Office is:  Primary  Specialist  Ancillary Billing Service

Will your office be using a Clearinghouse:  Yes  No

Clearinghouse Name: \_\_\_\_\_ Clearinghouse Contact: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_ Contact E-Mail Address: \_\_\_\_\_

Practice Management Software: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

**\*\*\* Offices must continue sending production claims while testing to avoid \*\*\*  
\*\*\* timely filing issues, even if that means billing via paper forms. Signing \*\*\*  
\*\*\* below acknowledges notification of this.\*\*\***

I will continue billing Via:  My old system  Paper  
Office Manager's Signature X\_\_\_\_\_

Test File Requirements:

- 1. A minimum submission of ten claims per tax identification number.
- 2. A sufficient claims sample reflective of routine billing.
- 3. If there are multiple providers within a group, claims from at least two providers are required.

**\*\*\* Office Use Only \*\*\***

Sender ID: \_\_\_\_\_ Implementation Date: \_\_\_\_\_ Orientation Date: \_\_\_\_\_

Submission Method:  Web Upload  Dial FTP  Internet FTP