



**EDI 837 Claims Enrollment Form
(To Send Electronic Claims to VPHP)**

Date

1 Submitter Information <i>(to be filled out by the clearinghouse)</i>		
CLEARINGHOUSE		
Clearinghouse Contact Name		
Email		
<i>[Note: VPHP will send enrollment confirmation to the email address above.]</i>		
2 Provider Group Information (W-9 Required)		
Group/Provider Name		
Group/Provider Tax ID		
Group/Provider NPI# (if applicable)		
3 Group/Provider Remittance/Billing Address		
Address		
City	State	Zip

Provider Name (including TITLE) (eg MD, DO, DPM)	Provider Specialty (eg Family Practice)	Provider NPI # (10 Digits)	Provider Taxonomy Code	PAR (Participating) OR Non-Par

[illegible]

- ❖ *If your clearinghouse instructs you to send this form directly to VPHP, either:*
 - *[Preferred]*
Email the completed form (as an attachment) to: **vphp_edi@vapremier.com**
 - Or -
 - Fax the completed form to: **877-289-9340**
- ❖ *Otherwise, send the form to your clearinghouse as per their instructions.*
- ❖ *Confirmation of your EDI Enrollment at VPHP will be emailed to the clearinghouse within ten business days.*
- ❖ *Questions about the status of your request should be directed to the clearinghouse, rather than to VPHP.*