



## VPHP Electronic Remit (EDI 835) Request Form

Date: \_\_\_\_\_

### Requester Information

Submitter Type     Individual                       Group Practice  
                          Clearinghouse                       Billing Agent

Submitter Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Phone Number : \_\_\_\_\_ Fax Number: \_\_\_\_\_

Contact Name : \_\_\_\_\_ Email Address: \_\_\_\_\_

### Billing Agent/Service Information

Billing Agent Name & Tax ID

\_\_\_\_\_

### Provider Group Information

Group Name \_\_\_\_\_

Group Tax ID \_\_\_\_\_

Group NPI # \_\_\_\_\_

Billing Address \_\_\_\_\_

Provider's Name \_\_\_\_\_

Provider's NPI# \_\_\_\_\_

Effective Date of EDI EOB: \_\_\_\_\_

Termination Date of EDI EOB: \_\_\_\_\_

- ❖ You may list additional providers and NPI#s on a separate attachment if necessary. Also, if provider is not affiliated with a group, please indicate as such.

### If you need additional information, please contact:

Virginia Premier Health Plan, Inc

Phone: 804-819-5151 or 800-727-7536

Fax: 804-819-5174

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