



EDI 837 Claims Enrollment Form

(To Send Electronic Claims to VPHP)

Date _____

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

Internal Use	
ID#	_____
W-9 on file	_____
Database	<input type="checkbox"/>
FAX	<input type="checkbox"/>
E-Mail	<input type="checkbox"/>
Date	_____

PROVIDER NAME (Including TITLE) (e.g. MD, DO, DPM)	PROVIDER SPECIALTY (e.g. Family Practice)	PROVIDER NPI # (10 Digits)	PROVIDER TAXONOMY CODE	PAR (Participating) Or Non-Par

