Independent Health.

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 with any questions.

Please indicate reason for request:

☐New EDI Submitter ☐Software Vendor Change ☐Other: _____

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

☐ANSI 837 Institutional ☐ANSI 837 Professional

Office Practice Name: _____ Date of Request: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____

Office Contact Person: _____ Contact Phone Number: _____

Fax Number: _____ E-Mail Address: _____

Tax ID#: _____ NPI Number(s): _____

Multiple Offices with same Tax ID#: ☐Yes ☐No

Multiple Offices with multiple Sender Id's: ☐Yes ☐No

Will your office be using a Clearinghouse: ☑Yes ☐No

Clearinghouse Name: <u>Claim Revolution, LLC</u> Clearinghouse Contact: <u>Brad Sharp</u>

Contact Phone Number: <u>918-842-9564</u> Contact E-Mail Address: <u>brad.sharp@claimrev.com</u>

Practice Management Software: _____ Contact Person: _____

Address: <u>19202 S 129th E Ave</u> City: <u>Bixby</u> State: <u>OK</u> Zip: <u>74008</u>

Phone: _____ E-Mail Address: _____

Desired Submission Method: ☐Web Upload ☐SSL with PGP Encryption ☐SFTP with PGP Encryption ☐CORE – HTTP MIME Multipart ☐CORE – SOAP + WSDL

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