SHARP HEALTH PLAN

Electronic Data Interchange (EDI)/Electronic Remittance Advice (ERA) Enrollment Form

1. Submission Date: _____ 2. Reason for Submission: _____

3. Expected Monthly Volume: _____

Provider Information			
4. Provider Name			
5. Specialty			
6. Provider Tax ID		8. Back-up Name	
7. Provider NPI		9. Back-up NPI	
Clearinghouse/Trading Partner Information			
10. Name			
11. Assigning Authority		12. Trading Partner ID	
Remittance Address Information - Must match EFT preference			
13. Payment Address			
14. City, State, Zip			
15. Phone No.		16. Fax No.	
Office Information			
17. Contact Name		20. Address	
18. Email		21. City, State, Zip	
19. Phone No.		22. Fax No.	
Claim Contact Information (if different from Office Info)			
23. Claim Contact		25. Phone No.	
24. Email		26. Fax No.	
Billing Company Information (if applicable)			
27. Billing Co.		29. Contact	
28. Phone No.		30. Email	

_____ _____

31. Signature 32. Title

Please submit completed form to:

Email: SHP.EDISupport@sharp.com

Fax: 858-499-8399

Mailing: Sharp Health Plan, Attn: EDI Dept, 8520 Tech Way Ste 200, San Diego, CA 92123

Questions: Please call 858-499-8378