



Dean

HEALTH PLAN

EDI Set-Up Form

Type of Practice/Group: Solo Group Hospital/Facility Billing Service

Type of Account: New Existing (indicate changes below)

Transaction Type:

837 Institutional claim <input type="checkbox"/>	837 Professional claim <input type="checkbox"/>	837 Dental claim <input type="checkbox"/>
835 Remittance <input type="checkbox"/>	834 Enrollment <input type="checkbox"/>	270/271 Eligibility <input type="checkbox"/>
278 Referral Request and Response <input type="checkbox"/>		820 Premium Payment <input type="checkbox"/>

Contact Information:

Name: _____ DHP Vendor Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Manager Contact: _____ Practice/Group Tax ID: _____

Telephone: (____) _____ Fax: (____) _____

E-Mail Address _____

If sending an 837 transaction, please fill out the next section

Confirmation Report Contact: _____ Telephone: (____) _____

Mailing address (if different than above) to mail Confirmation Report/Rejected Claims report:

Provider/Group Information:

Name of Provider/Group	Dean Health Plan Number	NPI Number

Payment Information (if different than above):

Name of Payee: _____ DHP Payee Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Payee Tax ID: _____

If you are using a Clearing House to submit your files, please fill out the next section

Clearing House Name: _____

Contact Person: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (____) _____ E-Mail Address: _____