



**University of Utah Health Plans - EDI Form**  
(835, 837 Trading Partner Setup and EFT Enrollment)

**PROVIDER INFORMATION**

Provider Name: \_\_\_\_\_

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

**PROVIDER IDENTIFIERS INFORMATION**

**Provider Identifiers**

Tax ID (TIN): \_\_\_\_\_ National Provider Identifier (NPI): \_\_\_\_\_

**Other Identifier(s)**

Clearinghouse Name or UHIN Trading Partner ID: \_\_\_\_\_

**PROVIDER CONTACT INFORMATION**

Provider Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Telephone Number Extension \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION**

Clearinghouse Name: \_\_\_\_\_

Clearinghouse Contact Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Telephone Number Extension \_\_\_\_\_

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



**FINANCIAL INSTITUTION INFORMATION FOR EFT ENROLLMENT**

Financial Institution Name: \_\_\_\_\_

Financial Institution Address: \_\_\_\_\_

Financial Institution Telephone Number: \_\_\_\_\_ Telephone Number Extension \_\_\_\_\_

Financial Institution Routing Number: \_\_\_\_\_

Provider’s Checking Account Number with Financial Institution\*: \_\_\_\_\_

Check if you want to submit claims electronically

**SUBMISSION INFORMATION**

Reason for Submission:      New Enrollment      Change Enrollment      Cancel Enrollment  
   Include with Enrollment Submission      Voided Check    OR      Bank Letter

Authorized Signature: \_\_\_\_\_

Printed Title of Person Submitting Enrollment: \_\_\_\_\_

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

Requested EFT Start/Change/Cancel Date: \_\_\_\_\_

Requested ERA Start/Change/Cancel Date: \_\_\_\_\_

**\* UUHP can only send EFT to checking accounts.**

*EFT request authorizes University of Utah Health Plans to deposit funds for claims payment directly into a vendor’s bank account. This request also allows for reversal of payments that were made in error. This authority is to remain in full force and effect until University of Utah Health Plans has received written notification from the vendor of its termination in such time and manner as to afford University of Utah Health Plans a reasonable opportunity to act on it.*

*Please send completed form to EDI Department, University of Utah Health Plans, fax #801-281-6121 or email: [uuhpEDI@hsc.utah.edu](mailto:uuhpEDI@hsc.utah.edu).*

*EDI participation is not an indication of contracting status. To verify contracting status, please contact customer service at (801) 587-6480.*

*Please include W9 if you have never submitted a claim to UUHP*