



**Request for Trading Partner Number**

**Setup for Filing Electronic Claims to Neighborhood Health Plan**

**Please provide the following Information:**

<b>Type of Account:</b>	<input type="checkbox"/> New	<input type="checkbox"/> Existing/Revision to TPA
-------------------------	------------------------------	---

Name of Person submitting this form:			
Phone Number:		Fax Number:	
Email Address:			

**Trading Partner/Submitter Information:**

<b>Practice Type:</b>		
<input type="checkbox"/> Community Health Center	<input type="checkbox"/> Clinic	<input type="checkbox"/> Hospital/Facility
<input type="checkbox"/> HealthCare Provider Office	<input type="checkbox"/> Clearing House	<input type="checkbox"/> Billing Service*

**\*Please Note: If a Billing Service is going to submit transactions on your behalf, NHP needs an authorization on the provider's corporate letterhead, allowing NHP to release your financial/patient information.**

<b>Health Care Provider Information:</b>			
Name:	Practice Tax ID Number		
Address:			
City:	State:	Zip	
Contact Person			
Phone Number	FAX		
E-mail address			

<b>If Payee Information is Different from Provider Information:</b>			
Name of Payee:			
Address:			
City:	State:	Zip	
NHP Vendor ID Number	Payee Tax ID Number		

Claims Filing Software Vendor Information:		
Vendor Name:		
Address:		
City:	State:	Zip
Vendor Contact Person		
Phone Number	FAX	
Vendor E-mail address		

Type of transactions that you wish to be authorized for:	
Transaction	With Addenda changes
<input type="checkbox"/> Claims Professional 837P	<input type="checkbox"/> version 5010
<input type="checkbox"/> Claims Institutional 837I	<input type="checkbox"/> version 5010
<input type="checkbox"/> Remittance 835	<input type="checkbox"/> version 5010
<input type="checkbox"/> Claims Status 276/277	<input type="checkbox"/> version 5010
<input type="checkbox"/> Eligibility 270/271	<input type="checkbox"/> version 5010
<input type="checkbox"/> Referral/Authorizations 278	<input type="checkbox"/> version 5010

I, \_\_\_\_\_ agree that in reference to 45 C.F.R. section §162.915 Trading Partner Agreements of the HIPAA regulations, that we will not do any of the following:

- (a) Change the definition, data condition, or use of a data element or segment in a standard.
- (b) Add any data elements or segments to the maximum defined data set.
- (c) Use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s).
- (d) Change the meaning or intent of the standard's implementation specification(s).

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Upon receipt of this, NHP will send a confirmation letter which will contain all identifications numbers necessary for you to send transactions to NHP.**