



# Group/Provider Access Information for 835 Transaction Set

Date: \_\_\_\_\_ Please Provide Current UserID(e.g SFT0001) \_\_\_\_\_

**Section I** Please complete a separate form for each Group and Provider number receiving a reimbursement voucher. (Information should be obtained from your most recent reimbursement voucher, see sample below)

Billing National Provider ID# (NPI): \_\_\_\_\_ (Required)

(1) CDPHP's Group or Provider number: \_\_\_\_\_

(2) Tax ID of Group/Provider: \_\_\_\_\_

Voucher/Remit Name and Address (Please print or type)

(3) Group/Provider Name: \_\_\_\_\_

(4)Address 1: \_\_\_\_\_

(5)Address 2: \_\_\_\_\_

(6)City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

|   |   |
|---|---|
| CAPITAL DISTRICT PHYSICIANS'<br>HEALTH PLAN, INC. (CDPHP)<br>PATROON CREEK CORPORATE CENTER<br>500 PATROON CREEK BLVD.<br>ALBANY, NEW YORK 12206-1057 | <b>PAYMENT VOUCHER</b>  |
| <p>3 Group/Provider Name</p> <p>4 Group/Provider Address 1</p> <p>5 Group/Provider Address 2</p> <p>6 Group/Provider City, State Zip</p>              | DATE: _____ PAGE:<br>TIN: <b>2</b><br>P 99999999 or<br>CHECK # G 9999 <b>1</b><br>AMOUNT: _____ |
|   | <b>FOR TELEPHONE INQUIRIES CALL:</b><br>(518) 641.3500  |

## Section II

Contact Information (Provider office contact)

Business Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Telephone: \_\_\_\_\_ Ext.: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Section III**

## Technical Contact Information (Vendor Contact details)

Technical Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Ext.: \_\_\_\_\_ Fax: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
Address 1: \_\_\_\_\_  
Address 2: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Complete the following only if you will have a 3<sup>rd</sup> party vendor retrieving your 835 transactions from CDPHP:

I authorize \_\_\_\_\_ to act as my agent to view Capital District Physicians' Health Plan, Inc. (CDPHP), Capital District Physicians' Healthcare Network, Inc. (CDPHN) or CDPHP Universal Benefits, Inc. (UBI) member data, including possible protect health information (PHI) in any format deemed appropriate by CDPHP, CDPHN or UBI, on my behalf. The entity listed above is my authorized business associate. I authorize the entity listed above to receive correspondence related to the submittal and processing of ANSI X12 835 transactions on my behalf.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Employer: \_\_\_\_\_

The NPI number should be the group practice's billing NPI, facility billing NPI, or individual practitioner NPI if a sole practitioner.

Please fax or mail to:

CDPHP  
Network Services department  
500 Patroon Creek Blvd.  
Albany, NY 12206  
FAX#: 518-641-3209

If you have connectivity questions, please contact the [EDI\\_Team@cdphp.com](mailto:EDI_Team@cdphp.com) or 518-641-4EDI(4334).

If you have questions concerning Section I through III, please contact Provider Services:

Capital area @ (518) 641-3500 or 1-800-926-7526, Central region @ 1-877-260-0512, Hudson Valley region @ 1-877-260-0801.