

Provider Demographic Information:

Name: _____

Mailing Address: _____ City: _____ State: ____ Zip Code: _____

Physical Address: _____ City: _____ State: ____ Zip Code: _____

Contact: _____ Telephone: _____ Fax: _____

Email: _____

Clearinghouse Information

Name: _____

Mailing Address: _____ City: _____ State: ____ Zip Code: _____

Physical Address: _____ City: _____ State: ____ Zip Code: _____

Contact: _____ Telephone: _____ Fax: _____

Email: _____

Do you want to receive your remittance advice electronically (835)? Yes No
(835 is an electronic copy of the payment data provided on the paper remittance)

I authorize the setup and/or change noted above for the EDI 837P transaction.

Print Name

Signature

Date

Title

To be completed by UHA
Transmitter ID: _____
Submitter ID: _____