



**EDI Set Up Form**

Type of Request:	<input type="radio"/> New	<input type="radio"/> Change (specify change below)	<input type="radio"/> Cancel
Type of Practice/Group:	<input type="radio"/> Physician/Provider	<input type="radio"/> Hospital/Facility	<input type="radio"/> Billing Service
Transaction Type:	<input type="radio"/> 837 Institutional	<input type="radio"/> 835 Remittance	
	<input type="radio"/> 837 Professional	<input type="radio"/> Pick up remit from Optima Health web site	(must have OH.com login id and password)

**PLEASE PRINT OR TYPE CLEARLY**

Provider Information	
Practice Name:	_____
Address:	_____
City:	_____ State: _____ Zip Code: _____
Telephone: ( ) _____	E-Mail Address: _____
Approval Name: (print)	_____
Signature/Title:	_____

Name of Provider/Group	Optima Health Vendor Number & Tax ID

**Banking Information (for electronic payments)**

Bank Name: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_ ACH Routing Number: \_\_\_\_\_

**Clearinghouse Information (for 837 or 835 only)**

Clearing House Name: \_\_\_\_\_

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

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

Contact Person: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Please allow up to 10 cal. days from receipt of documentation for EFT/ERA setup.  
 Please mail completed form with a voided check to Cindy Hunt at:

Optima Health Plan  
 4456 Corporation Lane, Suite 350  
 Virginia Beach, VA 23462