



**Payor Agreement Cover Sheet**

Agreement Type: Claims

CPID: \_\_\_\_\_ Payor Name: \_\_\_\_\_

Submitter ID: \_\_\_\_\_

Submitter Name: \_\_\_\_\_

Customer ID: \_\_\_\_\_

Billing ID: \_\_\_\_\_

Customer Contact: \_\_\_\_\_

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

Return completed agreement to:

McKesson  
Attn: Enrollment Dept. (IADU6)  
700 Locust Street  
Dubuque, IA 52001



This section for McKesson Internal Use:

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Appendix A: Tufts Health Plan EDI Set-up Form

Type of practice:       Solo  Group       Billing Service       Hospital/Facility  
 Type of account:               New       Existing (indicate changes below)  
 Type of claim billed:               837I (Institutional)       837P (professional)  
 Additional Transaction Type:       835       270  276       278

**Contact for solo, group, billing service client(s), hospital/facility**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
 Office contact: \_\_\_\_\_ Practice Tax ID: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ - \_\_\_\_\_ Fax: \_\_\_\_\_ - \_\_\_\_\_  
 E-Mail Address: \_\_\_\_\_  
 Practice Management System Vendor: \_\_\_\_\_ Submitter ID: \_\_\_\_\_  
 Vendor Contact Name: \_\_\_\_\_ - \_\_\_\_\_

**Payment Information**

Name of payee: \_\_\_\_\_ Tufts HP payee number: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
 Payee tax ID: \_\_\_\_\_

**Provider Information**

Name of Provider	Tufts HP Provider Number

Please contact EDI Operations (888-880-8699 x4042) if you have any questions regarding this form. EDI Operations will contact you after this information is verified to initiate electronic transactions.

Completed forms can be sent to [EDI\\_Operations@tufts-health.com](mailto:EDI_Operations@tufts-health.com) or faxed to 617-923-5555.