835 Payment Advice/ Remit Registration

P.O. Box 91110
Sioux Falls, SD 57109
(605) 328-6800 • 1-800 752-5863
Fax: (605) 328-6812
sanfordhealthplan.com

Processing Timeframe

Upon receipt, this form will be processed within 5 business days. Once the set-up is complete, the 835 remittance generation will be dependent on the next payment cycle that the specified provider's claims process on. Please ensure all information is complete and return this completed form via fax or email to:
Fax: 605-328-7224
Email providerrelations@sanfordhealth.org

Type of Request

☐ Initial request

Provider Change

☐ Add ☐ Update ☐ Remove

Trading Partner Information

All items must be completed legibly.

Trading partner name: ______________________________

Address *(include suite)*: ______________________________

City: ______________________________ State: __________ Zip: ______________

Contact name: ______________________________ Phone: (   ) ______________

Email address: ______________________________ Fax: (   ) ______________

Practice/facility name: ______________________________

Tax ID *(Must be 9 digits)*: ______________________________

Billing NPI ID: ______________________________

City: ______________________________ State: __________ Zip: ______________

Contact name: ______________________________ Phone: (   ) ______________

Provider email: ______________________________

_______ Additional pages accompany this registration page.

Practice/facility name: ____

Tax ID *(Must be 9 digits)*: ____

Billing NPI ID: ____

City: ____ State: __________ Zip: ________________

Contact name: __________________________________ Phone: (   ) ______________________

Provider email: ____

Practice/facility name: ____

Tax ID *(Must be 9 digits)*: ____

Billing NPI ID: ____

City: ____ State: __________ Zip: ________________

Contact name: __________________________________ Phone: (   ) ______________________

Provider email: ____

Practice/facility name: ____

Tax ID *(Must be 9 digits)*: ____

Billing NPI ID: ____

City: ____ State: __________ Zip: ________________

Contact name: __________________________________ Phone: (   ) ______________________

Provider email: ____

Practice/facility name: ____

Tax ID *(Must be 9 digits)*: ____

Billing NPI ID: ____

City: ____ State: __________ Zip: ________________

Contact name: __________________________________ Phone: (   ) ______________________

Provider email: ____