

VISION INSURANCE PLAN OF AMERICA, INC.
HIPAA File Transfer Set-Up Request
(ASC X12N 837P Format Only)
Fax Completed Request to 414-475-1599

Date Requested:	
Provider First Name:	
Provider Last Name:	
E-Mail Address:	
User Name (minimum 6 characters):	
Password (minimum 6 characters):	
Practice Name:	
Address #1:	
Address #2:	
City:	
State:	
Zip Code:	
Telephone:	
Fax:	