CONIFER HEALTH SOLUTIONS ERA ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- **Conifer EFT/ERA Authorization Agreement Form**
  - **Part VI: Electronic Remittance Advice Clearinghouse Information**
    - **Clearinghouse Name:** Availity
    - **Clearinghouse Contact Name:** Customer Service
    - **Telephone Number:** 1-800-282-4548
    - **Email Address:** N/A
  - **Note:** This form should be submitted first.
- **Conifer Health Solutions ERA Enrollment Form**

WHERE SHOULD I SEND THE FORM(S)?

- Email the **Conifer EFT/ERA Authorization Agreement Form** to EFTEnrollment@coniferhealth.com ***and*** Availity.ERA@officeally.com
- Email the **Conifer Health Solutions ERA Enrollment Form** to Availity.ERA@officeally.com

WHAT IS THE TURNAROUND TIME?

- Standard processing time is 30 business days.

HOW DO I CHECK STATUS?

- Send an email to Availity.ERA@officeally.com or call (360) 975-7000 opt 1 then opt 2.

CONIFER
HEALTH SOLUTIONS®

Electronic Funds Transfer (EFT) / Electronic Remittance Advice (ERA)
Authorization Agreement Form

FORM INFORMATION

FORM SUBMISSION:
Completed forms can be submitted *via* mail, fax or email to:
Attn: Finance Department
Conifer Value-Based Care
15821 Ventura Blvd., Suite 600
Encino, CA 91436
Fax: 818-461-5078

Email: EFTEnrollment@coniferhealth.com

CapConnect: www.capcms.com

FORMS QUESTIONS:
For EFT Questions: Customer Service
Phone: 818-461-5000

For ERA (835) Questions: Contact EDI Specialist
Email: ERASupport@coniferhealth.com

APPROVAL REQUESTS:
Confirmation will be sent *via* fax or e-mail upon completion of set-up. Allow up to 30 business days.

CONIFER
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Electronic Funds Transfer (EFT) / Electronic Remittance Advice (ERA) Authorization Agreement Form

PART I: PROVIDER AND IDENTIFIER INFORMATION

(1) Provider Name:

(2) Provider Federal Tax Identification Number (TIN):	(3) National Provider Identifier (NPI):

PART II: PROVIDER CONTACT INFORMATION

(4) Provider Contact Name:	(5) Title:

(6) Telephone Number:

(7) Email Address:

(8) Fax Number:

ELECTRONIC FUNDS TRANSFER SECTION:

(Skip to Part V- VII if enrolling in ERA only)

PART III: FINANCIAL INSTITUTION INFORMATION

(9) Financial Institution Name:

(10) Financial Institution Street Address:

(11) City:	(12) State: ☐	(13) Zip Code:
(14) Financial Institution Routing Number:	(15) Type of Account at Financial Institution:	☐ Checking ☐ Savings

(16) Provider's Account Number at Financial Institution:

(17) Account Number Linkage to Provider Identifier: *(Note: Must match ERA preference)*
Provider Tax Identification Number (TIN):

PART IV: SUBMISSION INFORMATION

(18) Reason for Submission:	☐ New Enrollment	☐ Change Enrollment	☐ Cancel Enrollment
(19) Include with Enrollment Submission: **Required for Processing (*EFT only*)**	☐ Voided Check	☐ Bank Letter (must be on the bank's letterhead)	

ELECTRONIC REMITTANCE ADVICE SECTION:

PART V: ELECTRONIC REMITTANCE ADVICE INFORMATION

(20) Preference for Aggregation of Remittance Data: *(Note: Must match EFT preference)*
Provider Tax Identification Number (TIN):

(21) Method of Retrieval

☐ Download from the Secured portal (Contracted Providers Only)

☐ Our Clearinghouse will retrieve all ERA files for us.
***Note**: Complete Clearinghouse Section below*

Your clearinghouse must have a relationship with our clearinghouse of choice: Availity

CONIFER
HEALTH SOLUTIONS®

Electronic Funds Transfer (EFT) / Electronic Remittance Advice (ERA) Authorization Agreement Form

PART VI: ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

(22) Clearinghouse Name:	(23) Clearinghouse Contact Name:
(24) Telephone Number:	
(25) Email Address:	

PART VII: SUBMISSION INFORMATION

(26) Reason for Submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Authorization (Applies to EFT only)

I hereby authorize clients of Conifer Value-Based Care to deposit, by electronic fund transfer, payments owed to the aforementioned provider and, if necessary, debit entries and adjustments for any amounts deposited in error. I recognize that if I fail to provide complete and accurate information on this Authorization Agreement the processing of the Agreement may be delayed or my payments may be erroneously transferred electronically. Conifer and its clients shall have no liability or responsibility for any payments erroneously transferred.

This Authorization Agreement is effective as of the signature date below and is to remain in full force and effect until Conifer has received written notification from the organization's authorized agent of a change or its termination in such time and such manner as to afford Conifer and the financial institution a reasonable opportunity to act on it. If the financial institution requires changes or if requesting termination of EFT, written notification must be submitted in the form of an updated Authorization Agreement.

I affirm all of the information contained in this enrollment application to be correct and true to the best of my knowledge. I understand providing false or misleading information on this enrollment application will result in rejection from the EFT payment program and that I will be responsible for any fees, legal or otherwise, incurred by Conifer or its clients on my behalf.

☐ I understand and agree to the EFT Authorization (Check Box) & enrollment will be applicable with any participating Conifer client

Authorized Signature (Applies to EFT and ERA)

(27) Written Signature of Person Submitting Enrollment:

(28) Printed Name of Person Submitting Enrollment:

(29) Printed Title of Person Submitting Enrollment:

(30) Submission Date: (31) Requesting EFT and/or ERA Start/Change/Cancel Date:

For Internal Use Only: Vendor # _____ **Company ID** _____
(Attach list of additional Vendor #/Facility # if applicable) Incident #: _____

EFT Set-Up Completed Date: _____ By: _____ EFT Effective Date: _____

ERA Set-Up Completed Date: _____ By: _____ ERA Effective Date: _____

Confirmation Sent To Provider on _____ By: _____ Method ☐ Fax ☐ E-mail

CONIFER HEALTH SOLUTIONS
ERA ENROLLMENT FORM

Email this form to Availity.ERA@officeally.com. The Email Subject should read: **Availity ERA Enrollment**.
Please make sure to print legibly and to complete this form in its entirety. You risk delaying enrollment if the application is unreadable or incomplete. All fields in **bold** are **required.**

PROVIDER INFORMATION

Provider Name:

Provider Address: **City:** **State:** **Zip:**

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number
Employer Identification Number (EIN): **National Provider Identifier (NPI):**

PROVIDER CONTACT INFORMATION

Contact Name: **Telephone Number/Extension:**

Email Address: Fax Number:

SUBMISSION INFORMATION

Reason for Submission: New Enrollment

Authorized Signature:

Note: Electronic Signature (Typed Name) of Person Submitting ERA Enrollment.