OPTUM CARE NETWORK (NAMM) (IP079)
ERA ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- **Electronic Remittance Advice (ERA) Enrollment Form**
- **Electronic Funds Transfer (EFT) Enrollment Form**
    - *Include a voided check or bank letter with EFT enrollment request*

WHERE SHOULD I SEND THE FORM(S)?

- Fax to (866) 596-7210; OR
- Email to EDIOperations@nammcal.com

WHAT IS THE TURNAROUND TIME?

- Standard processing time is 6-10 business days

HOW DO I CHECK STATUS?

- Email EDIOperations@nammcal.com to check the status of your ERA enrollment.

Electronic Remittance Advice (ERA) Enrollment Form

Return Completed Forms to:
Email:
EDIOperations@nammcal.com
Fax: (866) 596-7210
Mail: EDI Department
3990 Concours, Suite 500
Ontario, CA. 91764

Please PRINT clearly
Please note: Upon enrollment processing, Provider will receive both Paper Explanation of Payment and Electronic Remittance Advice (ERA) for 31 calendar days, after which time Provider will **only** receive ERA.

Provider Information (REQUIRED)

Provider Name:		
Provider Address Street:		
City:	State/Province:	Zip Code/Postal Code:

Provider Identifiers (REQUIRED)

Provider Federal Tax Identification Number (TIN) or Employer Identification Number:	
National Provider Identifier (NPI):	

Provider Contact Information

Provider Contact Name:		Title:
Telephone Number:	Telephone Number Extension:	Email Address:

Electronic Remittance Advice Information (REQUIRED)

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)
SELECT ONE

☐ Provider Tax Identification Number (TIN) ☐ National Provider Identifier (NPI)

Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name:

Submission Information

Reason for Submission: ☐ NEW Enrollment ☐ CHANGE Enrollment ☐ CANCEL Enrollment

The undersigned hereby certifies that the information provided herein is true and accurate in all respects and that he/she has been duly authorized by all necessary and appropriate corporation action, where applicable, to execute this agreement on behalf of the above mentioned Provider Name to form a legally binding contract. The undersigned authorizes Optum, PrimeCare Medical Network, Inc. (PMNI) and their affiliates (collectively referred to as "OPTUM") to transmit electronic remittance advice (ERA) detail for claims processed by OPTUM to the provider listed above. In addition, the undersigned hereby agrees that upon completion of enrollment processing, OPTUM will concurrently send paper explanation of payment and ERA for a period of 31 calendar days, after which time provider will only receive ERA.
This Authorization is to remain in full force and effect until OPTUM has received written notification of its termination in such time and manner as to afford OPTUM a reasonable opportunity to act on it.

Authorized Signature:_____ Date:_____

Printed Name of Person Submitting Enrollment

Electronic Funds Transfer (EFT) Enrollment Form

Return Completed Forms to:
Email:
EDIOperations@nammcal.com
Fax: (866) 596-7210
Mail: EDI Department
3990 Concours, Suite 500
Ontario, CA. 91764

Please PRINT clearly
Please allow 7-10 working days for Electronic Funds Transfer (EFT) enrollment processing.

Provider Information (REQUIRED)

Provider Name:		
Provider Address Street:		
City:	State/Province:	Zip Code/Postal Code:

Provider Identifiers (REQUIRED)

Provider Federal Tax Identification Number (TIN) or Employer Identification Number:	
National Provider Identifier (NPI):	

Provider Contact Information

Provider Contact Name:		Title:
Telephone Number:	Telephone Number Extension:	Email Address:

Financial Institution Information (REQUIRED)

Financial Institution Name:	
Financial Institution Routing Number:	Type of Account at Financial Institution: **(SELECT ONE)** ☐ **CHECKING** ☐ **SAVINGS**
Provider's Account Number with Financial Institution:	

Account Number Linkage to Provider Identifier: **(SELECT ONE)**

☐ Provider Tax Identification Number (TIN) ☐ National Provider Identifier (NPI)

Submission Information

Reason for Submission: ☐ NEW Enrollment ☐ CHANGE Enrollment ☐ CANCEL Enrollment

Include with Enrollment Submission (at least one) ☐ Voided Check ☐ Bank Letter

The undersigned hereby certifies that the information provided herein is true and accurate in all respects and that he/she has been duly authorized by all necessary and appropriate corporation action, where applicable, to execute this agreement on behalf of the above mentioned Provider Name to form a legally binding contract. The undersigned authorizes Optum, PrimeCare Medical Network, Inc. (PMNI) and their affiliates (collectively referred to as "OPTUM") to deposit payments for claims paid by OPTUM into the accounts listed above. In addition, the undersigned hereby agrees that OPTUM may initiate credit entries and/or initiate error adjustments for duplicate or erroneous entries made to the account listed above.
This Authorization is to remain in full force and effect until OPTUM has received written notification from the undersigned of its termination in such time and manner as to afford OPTUM a reasonable opportunity to act on it.

Authorized Signature:_____ Date:_____

Printed Name of Person Submitting Enrollment