ACCESS MEDICAL GROUP (AMG02) ERA-ENROLLMENT INSTRUCTIONS

WHICH FORMS SHOULD I COMPLETE?

- **835 Enrollment Information Form** (Pg. 2)
- **Authorization for ACH Deposit of Vendor Payment** (Pg. 3)

WHERE SHOULD I SEND THE FORM(S)?

- The completed **835 Enrollment Information Form** & **Authorization for ACH Deposit of Vendor Payment** forms can be emailed to edisupport@allcaretoyou.com

HOW DO I CHECK STATUS?

- Standard processing time can take up to 10 business days.

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- If you have not started receiving your (ERA) Electronic Remittance Files after the allotted timeframe, you can reach out to edisupport@allcaretoyou.com to confirm if you are now approved with Office Ally for the 835/ERA transaction.

Office Ally

835-ENROLLMENT INFORMATION FORM

PROVIDER INFORMATION

Provider Name:

Provider Address:

PROVIDER IDENTIFIER INFORAMTION

Tax Identifier (TIN or EIN):

National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION

Provider Contact Name:

Telephone Number:

Email Address:

PAYER NAME

Name of Payer Enrolling: Access Medical Group

SUBMISSION INFORMATION

Authorized Signer Name & Title:

Authorized Signature:

***NOTE**: Electronic Signature (typed name) of person submitting ERA Enrollment*

Access Medical Group, Inc.
"Opening Doors To Better Health"

Access Medical Group C/O
All Care To You
P.O. Box 4367
Orange, CA 92863

AUTHORIZATION FOR ACH DEPOSIT OF VENDOR PAYMENT

Payee/Vendor Name

Address

City, State Zip

Telephone

Contact Name

Contact e-mail
(for ACH remittance notification)

Complete this section for **new enrollments** or for **financial institution or account changes.**

Select one: ☐ New Enrollment ☐ Financial Institution or Account Change

Bank Name

Branch (if applicable)

City, State Zip

Transit/Routing Number

Bank Account Number

Account Type (check one) ☐ Checking Account ☐ Savings Account

I, the undersigned, authorize the Access Medical Group/Access Medical Group Santa Monica to deposit payments directly to the account indicated above and to correct any errors which may occur from the transactions. I also authorize the financial institution named above to post these transactions to that account. This authorization will remain in force until AMG/ASM receives written notice of cancellation from me. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

Signature Date

Name (printed) Title

Complete this section to **CANCEL** your ACH electronic deposit authorization.

I, the undersigned, hereby cancel the authorization for the Access Medical Group/Access Medical Group Santa Monica to originate ACH electronic deposit entries into my checking/savings account. This cancellation is effective as soon as AMG/ASM has reasonable time to act upon it.

Signature Date

Name (printed) Title

Mail the completed form to the address above, fax to (949)396-2614 or email to MikeSayed@AllCareToYou.com

For AMG/ASM Use Only

Vendor Number _____ Date Received _____