ALL CARE TO YOU
ERA-ENROLLMENT INSTRUCTIONS

WHICH FORMS SHOULD I COMPLETE?

- **835 Enrollment Information Form** (Pg. 3)
- **Authorization for ACH Deposit of Vendor Payment** (Pg. 4)

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.

HOW DO I CHECK STATUS?

- 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.

WHAT PAYERS ARE INCLUDED IN THIS ENROLLMENT?

- All the below payers will be enrolled when you complete the request:

OA Payer Name	Payer ID
Access Medical Group	AMG02
AMG IPA - Ava Medical Group	AMIPA
Arrowhead Regional Medical Center	ARMC1
El Camino Health Alliance	ECL01
El Camino Health Medical Network	S9637
Empire Healthcare IPA	EHI01
Genesis Medical Group	GMG01
Healthy Medical Group	HMG01
In Physicians Associates – ACTY	INP12
Kova Healthcare, Inc.	KOVA1
Superior Choice Medical Group	SCPR1
ViCare Health	VCH01

Office Ally

ALL CARE TO YOU
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 LIST

Check the boxes for all payers you are requesting Electronic Remittance Advice enrollment(s):

☐	Access Medical Group (AMG02)	☐	Genesis Medical Group (GMG01)
☐	AMG IPA – Ava Medical Group (AMIPA)	☐	Healthy Medical Group (HMG01)
☐	Arrowhead Regional Medical Center (ARMC1)	☐	In Physicians Associates – ACTY (INP12)
☐	El Camino Health Alliance (ECL01)	☐	Kova Healthcare, Inc. (KOVA1)
☐	El Camino Health Medical Network (S9637	☐	Superior Choice Medical Group (SCPR1)
☐	Empire Healthcare IPA (EHI01)	☐	ViCare Health (VCH01)

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 _____