BMC HEALTHNET PLAN (13337)
ERA/EFT ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- ERA Authorization Form (ERA-1)
- EFT Authorization Form (EFT-1) - optional

WHERE SHOULD I SEND THE FORM(S)?

- Email the ERA form to: ERA.REQUESTS@bmchp-wellsense.org
- Return the EFT form to your BMC Provider Relations representative

WHAT IS THE TURNAROUND TIME?

- Standard processing time is 1-2 weeks.

BOSTON MEDICAL CENTER
HEALTHNet PLAN

ERA Authorization Form (ERA-1)

Please Check One: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Provider Identification Information

Provider Name	
Provider Tax Identification Number or Employer Identification Number	
Provider National Provider Identifier (NPI)	
Provider Contact Information:	
Name	
Telephone Number	
E-Mail Address	

Account Number Linkage Information

Account Number Linkage to Provider Identifier	
Provider Tax Identification Number or Employee Identification Number	
Provider National Provider Identifier (NPI)	

Authorization Information

Authorized Signature	
Electronic Signature of Person Submitting Enrollment	
Written Signature of Person Submitting Enrollment	
Printed Name of Person Submitting Enrollment	
Printed Title of Person Submitting Enrollment	
Submission Date	
Requested ERA Start/Change/ Cancel Date	

Clearinghouse Information

Official name of the provider's clearinghouse	Office Ally, Inc.

Vendor Information

Official name of the provider's vendor	

Please return this form to ERA.Requests@bmchp.org

EFT Authorization Form (EFT-1)

Please Check One:

☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

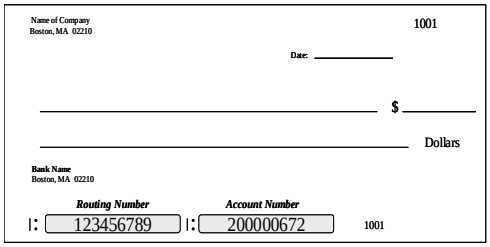
Provider Identification Information

Provider Name	
Provider Tax Identification Number or Employer Identification Number	
Provider National Provider Identifier (NPI)	
Provider Contact Information:	
Name	
Telephone Number	
E-Mail Address	

Financial Institution Information

Financial Institution Name	
Financial Institution Address:	
Street	
City	
State/Province	
ZIP Code / Postal Code	
Account Type	
ACH Routing Transit Number	

Provider's Financial Institution Account Number	



NOTE: A *VOIDED CHECK or LETTER from bank confirming ABA Transit and Account Numbers, or LETTER from Provider on Provider's Letterhead, signed by authorized signer confirming ABA Transit and Account Numbers and explaining why a voided check cannot be provided* must be attached.

Account Number Linkage to Provider Identifier		
Provider Tax Identification Number or Employee Identification Number		
Provider National Provider Identifier (NPI)		

Authorization Information

Authorized Signature		
Electronic Signature of Person Submitting Enrollment		
Written Signature of Person Submitting Enrollment		
Printed Name of Person Submitting Enrollment		
Printed Title of Person Submitting Enrollment		
Submission Date		
Requested EFT Start/Change/ Cancel Date		

Please return this form to your Provider Relations Representative.