CIGNA HEALTHCARE (62308) ERA ENROLLMENT

Email this form to support@officeally.com or Fax to (360) 896-2151. Once your form is received and processed, Office Ally will send you a confirmation via email. If you do not receive a confirmation email from us within 2-3 days of sending this form, please send it again. 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 (AS IT APPEARS ON YOUR W-9):

Billing Provider Name:

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

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

ADDITIONAL PROVIDER INFORMATION (IF APPLICABLE):

Solo Practitioner Name: Facility Name:

PROVIDER CONTACT INFORMATION:

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

Email Address: Fax Number:

ELECTRONIC REMITTANCE ADVICE INFORMATION:

Preference for Aggregation Of Remittance Data: **TIN:**

NPI:

Note: *Account Number Linkage to Provider Identifier. Must match preference for EFT payments. Choose only* ***one****.*

SUBMISSION INFORMATION:

Reason for Submission: **Provider Type:**

Authorized Signature:

Note: *Electronic Signature (typed name) of Person Submitting ERA Enrollment.*