CIGNA HEALTHCARE (62308)
ERA ENROLLMENT

Email this form to enrollmentadmin@officeally.com or Fax to (360) 314-2184. Once your form is received and processed Office Ally will e-mail or call you. If you do not receive a confirmation e-mail/call from us within 2-3 days of faxing this form to us, please fax 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 (CHECK ONLY ONE)

Preference for Aggregation of Remittance Data: (i.e. Account Number Linkage to Provider Identifier). Note: Provider Preference for grouping (bulking) claim payment advice. Must match preference for EFT payment (i.e. Billing Provider). Choose and fill in only **one**.

☐ Provider Federal Tax Identification Number (TIN):

☐ National Provider Identifier (NPI):

SUBMISSION INFORMATION

Reason for Submission: Enroll **Provider Type:** Medical/Behavioral

Authorized Signature:

Submit by Email

Clear Form

Note: Electronic Signature (Typed Name) of Person Submitting ERA Enrollment.

Standard processing time is 14 business days