

WHICH FORMS SHOULD I COMPLETE?

- Complete the **Conifer EFT/ERA Authorization Agreement Form** (Pg. 2-4)

WHERE SHOULD I SEND THE FORM(S)?

- Email the **Conifer EFT/ERA Authorization Agreement Form** to EFTEnrollment@coniferhealth.com AND Availity.ERA@OfficeAlly.com
 - o Please list the following as the **Subject Line** in your email: **Conifer ERA Enrollment - (Insert NPI)**
 - o You will receive an auto-generated email returning a case number for your submission to Availity.ERA@officeally.com. You will need this case number to follow up on status.

WHAT IS THE TURNAROUND TIME?

- Standard processing time is 30 Business Days

HOW DO I CHECK STATUS?

- To check status of your request, please reach out to Office Ally's Payer Enrollment team at PayerEnrollment@OfficeAlly.com. Be sure to reference the auto-generated Office Ally case number that was returned upon the submission of your request.

**Electronic Funds Transfer (EFT) / Electronic Remittance Advice (ERA)
Authorization Agreement Form**

FORM INFORMATION

FORM SUBMISSION:

Completed forms can be submitted *via* mail, fax or email to:

Attn: Finance Department

Conifer Value-Based Care

15821 Ventura Blvd., Suite 600

Encino, CA 91436

Fax: 818-461-5078

Email: EFTErollment@coniferhealth.com

CapConnect: www.capcms.com

FORMS QUESTIONS:

For EFT Questions: Customer Service

Phone: 818-461-5000

For ERA (835) Questions: Contact EDI Specialist

Email: ERASupport@coniferhealth.com

APPROVAL REQUESTS:

Confirmation will be sent *via* fax or e-mail upon completion of set-up. Allow up to 30 business days.

**Electronic Funds Transfer (EFT) / Electronic Remittance Advice (ERA)
Authorization Agreement Form**

PART I: PROVIDER AND IDENTIFIER INFORMATION

(1) Provider Name:

(2) Provider Federal Tax Identification Number (TIN):

(3) National Provider Identifier (NPI):

PART II: PROVIDER CONTACT INFORMATION

(4) Provider Contact Name:

(5) Title:

(6) Telephone Number:

(7) Email Address:

(8) Fax Number:

ELECTRONIC FUNDS TRANSFER SECTION:

(Skip to Part V- VII if enrolling in ERA only)

PART III: FINANCIAL INSTITUTION INFORMATION

(9) Financial Institution Name:

(10) Financial Institution Street Address:

(11) City:

(12) State:

(13) Zip Code:

(14) Financial Institution Routing Number:

(15) Type of Account at Financial Institution: Checking Savings

(16) Provider's Account Number at Financial Institution:

(17) Account Number Linkage to Provider Identifier: *(Note: Must match ERA preference)*

Provider Tax Identification Number (TIN):

PART IV: SUBMISSION INFORMATION

(18) Reason for Submission: New Enrollment Change Enrollment Cancel Enrollment

(19) Include with Enrollment Submission: Voided Check Bank Letter (must be on the bank's letterhead)
Required for Processing (EFT only)

ELECTRONIC REMITTANCE ADVICE SECTION:

PART V: ELECTRONIC REMITTANCE ADVICE INFORMATION

(20) Preference for Aggregation of Remittance Data: *(Note: Must match EFT preference)*

Provider Tax Identification Number (TIN):

(21) Method of Retrieval

Download from the Secured portal (Contracted Providers Only)

Our Clearinghouse will retrieve all ERA files for us.

Note: Complete Clearinghouse Section below

Your clearinghouse must have a relationship with our clearinghouse of choice: Availity

**Electronic Funds Transfer (EFT) / Electronic Remittance Advice (ERA)
Authorization Agreement Form**

PART VI: ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

(22) Clearinghouse Name: Availity (23) Clearinghouse Contact Name: Customer Service

(24) Telephone Number: 1-800-282-4548

(25) Email Address: N/A

PART VII: SUBMISSION INFORMATION

(26) Reason for Submission: New Enrollment Change Enrollment Cancel Enrollment

Authorization (Applies to EFT only)

I hereby authorize clients of Conifer Value-Based Care to deposit, by electronic fund transfer, payments owed to the aforementioned provider and, if necessary, debit entries and adjustments for any amounts deposited in error. I recognize that if I fail to provide complete and accurate information on this Authorization Agreement the processing of the Agreement may be delayed or my payments may be erroneously transferred electronically. Conifer and its clients shall have no liability or responsibility for any payments erroneously transferred.

This Authorization Agreement is effective as of the signature date below and is to remain in full force and effect until Conifer has received written notification from the organization's authorized agent of a change or its termination in such time and such manner as to afford Conifer and the financial institution a reasonable opportunity to act on it. If the financial institution requires changes or if requesting termination of EFT, written notification must be submitted in the form of an updated Authorization Agreement.

I affirm all of the information contained in this enrollment application to be correct and true to the best of my knowledge. I understand providing false or misleading information on this enrollment application will result in rejection from the EFT payment program and that I will be responsible for any fees, legal or otherwise, incurred by Conifer or its clients on my behalf.

I understand and agree to the EFT Authorization (Check Box) & enrollment will be applicable with any participating Conifer client

Authorized Signature (Applies to EFT and ERA)

(27) Written Signature of Person Submitting Enrollment:

(28) Printed Name of Person Submitting Enrollment:

(29) Printed Title of Person Submitting Enrollment:

(30) Submission Date:

(31) Requesting EFT and/or ERA Start/Change/Cancel Date:

For Internal Use Only: Vendor # _____
(Attach list of additional Vendor #/Facility # if applicable)

Company ID _____
Incident #: _____

EFT Set-Up Completed Date: _____ By: _____ EFT Effective Date: _____

ERA Set-Up Completed Date: _____ By: _____ ERA Effective Date: _____

Confirmation Sent To Provider on _____ By: _____ Method Fax E-mail
