EPIC MANAGEMENT
ERA-ENROLLMENT INSTRUCTIONS

WHICH FORMS SHOULD I COMPLETE?

The payer(s) require EFT Enrollment to retrieve ERA files.

- **Epic Management Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Authorization Agreement (page 2-3)**
  - **You must attach a voided check or bank letter**
  - **Instructions for completing form are available on pages 4-5**

WHERE SHOULD I SEND THE FORM(S)?

- Mail to: Epic Management L.P., Claims Department, ATTN: Accounting
  10393 Enterprise Drive, Redlands, CA 92374

WHAT IS THE TURNAROUND TIME?

- Standard Processing Time can take up to 30 business days.

WHICH PAYERS CAN BE ENROLL THROUGH EPIC MANAGEMENT?

Payer Name	Payer ID	Payer Name	Payer ID
Alliance Physicians High Desert	22417	Fenix Medical Group EHP	33649
Alliance Physicians High Desert EHP	25542	Pinnacle Medical Group	95271
Beaver Medical Group	45967	Pinnacle Medical Group EHP	74662
Beaver Medical Group EHP	77668	Redlands Yucaipa Medical Group EHP	73398
Chaffey Medical Group	49533	Redlands-Yucaipa Medical Group	18247
Chaffey Medical Group EHP	22333	Tri Valley Medical Group EHP	87482
Family Practice Medical Group EPIC	10145	Tri-Valley Medical Group	20538
Fenix Medical Group	60818		

HOW DO I CHECK STATUS?

If you have any questions regarding the EFT / ERA enrollment process, contact our Claims Department by telephone at 1-855-374-2571

Epic Management Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Authorization Agreement

The information you provide on this Electronic Funds Transfer and Electronic Remittance Advice Authorization Agreement is used to establish the Trading Partner relationship between Epic Management, L.P. and your organization. By completing and signing this form, your company authorizes Epic Management to transmit remittance advice data in an X12-5010 format and to make electronic payments.

Provider Information		
Provider Name*:		
Doing Business As Name (DBA):		
Street*:		
City*:	State/Province*:	ZIP Code/Postal Code *:

Provider Identifiers Information	
☐ Provider Federal Tax Identification Number (TIN) ☐ Employer Identification Number (EIN)*	
National Provider Identifier (NPI) (Submit additional NPIs on a new sheet of paper)*:	
Assigning Authority*:	

Provider Contact Information	
Provider Contact Name*:	
Title:	
Telephone Number*:	Telephone Number Extension:
Email Address*:	

Financial Institution Information		
Financial Institution Name*:		
Street*:		
City*:	State/Province*:	ZIP Code/Postal Code*:
Financial Institution Telephone Number:		
Financial Institution Routing Number*:		
Provider's Account Number with Financial Institution*:		
Type of Account at Financial Institution* (select one): ☐ Checking account ☐ Savings account		
Account Number Linkage to Provider Identifier*: ☐ Provider Tax Identification Number (TIN) ☐ National Provider Identifier (NPI)		
If enrolling in the 835 Electronic Remittance Advice (ERA), the provider must contact its financial institution to arrange for the		

delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the 835 ERA.

Vendor Information	
Vendor Name	Office Ally
Vendor Contact Name	Payer Enrollment Department
Telephone Number	360-975-7000
Email Address	payerenrollment@officeally.com

Submission Information

Reason for Submission (Only for ERA. Contact Epic Management to change or cancel enrollment in Electronic Funds Transfer)*:
☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

A voided check from the provider's account or a letter from the financial institution on financial institution letterhead specifying the provider's name, the account and financial institution routing/ABA number must be included with the signed EFT Authorization Agreement.

☐ Voided check ☐ Bank letter

Authorization

EFT Only

I hereby authorize Bank of America, on behalf of Epic Management L.P., to deposit by electronic funds transfer, payments owed to the aforementioned provider, and if necessary, debit entries and adjustments for any amounts deposited in error. Bank of America shall deposit the payments in the designated financial institution's account. 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. Epic Management L.P. shall have no liability or responsibility for any payments erroneously transferred.

I affirm all of the information contained in this enrollment application to be correct and true to the best of my knowledge. I understand that 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 Epic Management L.P. on my behalf. By signing below, I hereby agree that I have read and agree to the terms and conditions. Furthermore, the undersigned certifies that the information provided is true and accurate and that they have the authority to sign this form

Authorized Signature*:	Submission date*:
Printed name of person submitting enrollment*:	Printed title of person submitting enrollment*:
Requested ERA Start/Change/Cancel Date:	

This EFT / ERA Authorization Agreement must be fully completed, signed and returned via U.S. Mail to:

Epic Management L.P.
Attention: Accounting
10393 Enterprise Drive
Redlands, CA 92374

If you have any questions regarding the EFT / ERA enrollment process, contact our Claims Department by telephone at 1-855-374-2571.

Instructions to Complete the EFT / ERA Authorization Agreement

Here we should add some very high-level information on the timeline and process for onboarding. For example, "All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made."

Provider Information:

Provider Name	Type the complete legal name of your institution, corporate entity, practice, or individual provider.
Doing Business As Name (DBA)	The DBA is a business name that differs from your personal name, the names of your partners, or the officially registered name of your institution, corporate entity, or practice
Provider Address Information	
Street	The number and street name of your company or organization.
City	The city associated with the provider address field.
State/Province	Type the two character code associated with the state where the provider is located.
ZIP Code/Postal Code	Type the provider ZIP Code

Provider Identifiers Information:

Select either the Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) checkbox and type the corresponding number in the provided space. Enter the TIN as you report it to the IRS. If the business is a corporation, provide the Federal EIN.

Type the National Provider Identifier (NPI) if your organization has one. You can type up to four NPIs in the provided fields, please report any additional NPI numbers on a separate sheet of paper.

Assigning Authority	The organization that issues and assigns the NPI to your organization.
Trading Partner ID	The provider's submitter ID assigned by the health plan or the

Provider Contact Information:

Provider Contact Name	Type the name of a contact in the provider's office who will handle ERA / EFT questions and issues.
Title	Type the provider contact's title.
Telephone Number	Type the provider contact's telephone number.
Email Address	Type the provider contact's email address.

Financial Institution Information:

Financial Institution Name	Type the official name of your Depository Financial Institution (DFI).
Financial Institution Address Information:	
Street	The street address associated with your depository financial institution.
City	The city associated with the receiving depository financial institution address field.
State/Province	The two-character code associated with the state where the receiving depository financial institution is located.
ZIP Code/Postal Code	Type the receiving depository financial institution ZIP Code
Financial Institution Telephone Number	Type the receiving depository financial institution telephone number.
Financial Institution Routing Number	Type the 9-digit identifier of the provider's financial institution where the payments are to be deposited. Include applicable leading zeros.

Provider's Account Number with Financial Institution	Type the provider's account number at the financial institution to which EFT payments are to be deposited. Include applicable leading zeros.
Type of Account at Financial Institution	Select the type of account you will use to receive EFT payments.
Account Number Linkage to Provider Identifier	Provider preference for grouping (bulking) claim payments. This must match the preference for v5010 X12 835 remittance advice.

Submission Information:	
Vendor Name	Official name of the provider's vendor.
Vendor Contact name	Name of a contact in the vendor office for handling ERA issues.
Telephone Number	Telephone number of Contact
Email Address	An electronic mail address at which the health plan might contact the provider's vendor.

Submission Information:	
Reason for Submission	Select New, Change, or Cancel Enrollment.
Include with enrollment submission	Select and include either a voided check or a bank letter to confirm account information. A voided check is used to confirm Identification/Account Numbers. A statement on bank letterhead must formally certify your routing and account numbers, as well as include the financial institution officer's name and signature.

Authorization

Add printing information here if creating an Adobe form.

Contact the Epic Management's Claims Department at 1-855-374-2571 if you have any questions regarding the form.

Before you submit this Agreement, please ensure that:

- All information on the form is valid and typed correctly
- You include a voided check or bank letter