Office Ally

ECHO HEALTH
ERA-ENROLLMENT INSTRUCTIONS

WHICH FORMS SHOULD I COMPLETE?

- **Echo EFT/ERA Enrollment Form**
  - Follow instructions at the top of the form.
  - Only ONE Payer can be listed on each Echo Enrollment form. If you would like to enroll with multiple Payers, multiple forms must be submitted.

WHERE SHOULD I SEND THE FORM(S)?

Email To: EDI@EchoHealthInc.com

Mail To: ECHO Health Inc.
810 Sharon Dr
Westlake, OH, 41145

WHAT IS THE TURNAROUND TIME?

The Time it takes ERAs to start coming through to Office Ally is dependent upon each individual Payer. Generally, ERAs can take anywhere from 14-45 business days to begin coming through.

HOW DO I CHECK STATUS?

To check the status of your enrollment request, please contact ECHO at 440-835-3511 or by email at EDI@EchoHealthInc.com

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ECHO HEALTH ERA PAYERS OFFERED (1/2)

ONLY ONE PAYER CAN BE LISTED PER ENROLLMENT FORM

Payer ID	Payer Name	Payer ID	Payer Name
72467	ACS Benefit Services	75136	CoreSource Little Rock
62118	Aetna Genworth Life Insurance	58102	Covenant Administrators
13334	Affinity Health Plan	39081	Custom Benefit Administrators
ALTAM	AltaMed	82056	Custom Design Benefits
20029	America's Choice Healthplan	MCS03	Delano Regional Medical Group (MCS)
26119	American Insurance Administrators	37253	ELMCO (PHX)
44444	American Postal Workers Union (APWU)	37216	Employee Benefit Services
77013	AmeriHealth Caritas	37215	Employee Benefits Corporation
45408	AmeriHealth Caritas Next Florida	45319	Evergreen Health
64090	Amfirst insurance	59313	Evolution Healthcare
84323	Banner Medicare Advantage Plus PPO	MCS03	GemCare Medical Group (MCS)
84324	Banner Medicare Advantage Prime HMO	25531	Group Health, Inc. HMO (Emblem)
66901	Banner University Care LTC	13551	Group Health. Inc. PPO (Emblem)
88030	Baylor Scott and White Health Care Plan	47083	Group Management Services (GMS)
39081	Benefit Plan Administrators (WI)	62111	Health Cost Solutions
68011	Capitol Administrators	80142	Health Partners Plans (PA)
CARMO	Carelon Health – Palliative Care	HMA01	Healthcare Management Administrators
GACS1	CareSource of Georgia	71063	HealthSCOPE Benefits
KYCS1	Caresource of Kentucky	37272	HealthSmart Benefit Solutions (JSL)
INCS1	CareSource of Indiana	37283	HealthSmart Benefit Solutions (AA/GB)
INCS1	CareSource Marketplace	87815	HealthSmart Benefit Solutions (WF/AN)
31114	CareSource of Ohio	55247	HIP Health Plan of NY
CAS89	CAS Coastal Administrative Services	00257	Highmark Health
65391	CBHNP – Health Choice	74431	InHealth (Ohio PPO Connect)
CHOC1	CHOC Health Alliance	IMSMS	Insurance Management Services
CCA01	Central California Alliance for Health (CCAH)	51020	Integra Administrative Group
38219	Claimchoice Administrators (formerly AmeraPlan)	RP075	Iowa Health Advantage
85468	Clear Spring Health	52189	John Hopkins Healthcare
77052	Coastal TPA (Coastal Administrative)	IP085	Kaweah Delta HC District Emp Plan
COACC	Colorado Access	IP084	Kaweah Delta Medicare Advantage
35193	Community Health Alliance	IP082	Key Medical Group
27905	Community Health Alliance (TN)	IP083	Key Medical Group – Medicare Advantage
48145	Community Health Choice	LCB01	Line Constructions Benefit Fund
45321	Consumers Choice Health Plan	01260	Magellan Behavioral Health
78375	Connecticare Medicare	MCS03	Managed Care Systems (MCS)
47165	Core Benefits	20805	Marrick Medical Finance
35182	CoreSource (AZ/IA/IL/IN/MD/MN/PA)	60230	Masonry Welfare Trust Fund
35183	CoreSource (OH)	04293	Mass General Brigham Health Plan
35187	CoreSource Internal	25160	MCA Administrators

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ECHO HEALTH ERA PAYERS OFFERED (2/2)

ONLY ONE PAYER CAN BE LISTED PER ENROLLMENT FORM

Payer ID	Payer Name	Payer ID	Payer Name
39190	MedStar Family Choice	TH023	WellMed Medical Management Inc.
RP062	MedStar Family Choice DC	93050	William C. Earhart Company
RP063	MedStar Family Choice MD	62111	W.C Beeler & Company
22823	Med-American Benefits		
41124	Meritain Health		
MCC02	Molina Complete Care Virginia		
38333	Molina Healthcare		
20149	Molina Healthcare of Ohio		
SX109	Molina Healthcare of Utah		
37256	Mutual Assurance Administrators		
39144	Network Health Plan of WI		
38225	NGS American		
81264	Nippon Life Benefits		
88027	Northern Nevada Trust Fund (BPA)		
04218	Pan American Life Insurance		
SLOS1	Physicians Choice Medical Group of San Luis Obispo		
MCI01	Physicians Choice Medical Group of Santa Maria		
55768	Piedmont Community Health Plan		
37224	Pittman & Associates (HealthSmart Benefit)		
CB404	Preferred Health Plan of the Carolinas		
35174	QualChoice of Arkansas		
HMA01	Regence Group Administrators (RGA)		
37278	ResourceOne		
50114	Sana Benefits		
72261	SCAN Health Plan		
23285	Select Health of South Carolina		
87020	Sentinel Security Life Insurance Company		
SIM02	SIMPRA Advantage		
83245	Southwestern Health Resources		
25463	Surest (previously Bind)		
TKFMC	TKFMC		
42137	TriStar		
91078	Trusteed Plans Service Corporation		
61425	Trustmark Insurance Company / Starmark		
74227	UHC Student Resources		
52180	UMWA Health & Retirement Funds		
89070	United Concordia		

ECHO® Payments *Simplified*

EFT (Electronic Funds Transfer) and ERA (Electronic Remittance Advice) Enrollment Form

INSTRUCTIONS

- This is a fillable form. Type your information into the form on your screen, or print the form and fill in the information.
- Complete all sections that apply to your enrollment choice (EFT, ERA, or both EFT and ERA).
- Enrollments are handled at the TAX ID level. All NPIs associated with the specified TIN will be automatically enrolled.
- If your TAX ID would like to receive payments via more than one bank account, please contact EDI@EchoHealthinc.com.
- Be sure to sign the form. Postal mail or email the completed form (secure email recommended). Postal mail: ECHO Health, Inc., 810 Sharon Drive, Westlake, Ohio 44145. Email: EDI@EchoHealthinc.com.
- For information about the status of your enrollment, or for any other questions, please contact ECHO at 440.835.3511 or EDI@EchoHealthinc.com.

You will need to contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation.

Payer / Insurance Company Name: ______________________________

(Please specify only one Payer per form)

For security purposes, please supply an ECHO Draft Number and matching Draft Amount to validate against your Tax ID. The Draft Number will be a 9-digit payment number beginning with a 1 or a 9. **NOTE:** For **ERA only**, Draft Number and Draft Amount are ***not required***.

ECHO Draft Number ______________________ **ECHO Draft Amount** $ ____________________

1-Form Select *(Required)*

◯ **EFT & ERA** ◯ **EFT Only** ◯ **ERA Only**

2-Provider Information *(Required)*

Provider Name: ______________________________

(Complete legal name of institution, corporate entity, practice or individual provider)

Street: ______________________________

(The number and street name where a person or organization can be found)

City: ____________________

(City associated with provider address field)

State/ Province: Alabama-AL

(ISO-3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.)

ZIP Code/Postal Code: ____________

(System of postal-zone codes [zip stands for "zone improvement plan"] introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.)

3-Provider Identifiers Information *(Required)*

Provider Identifiers

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): ____________

(A Federal Tax Identification Number, also known as an Employer Identification Number [EIN], is used to identify a business entity)

Does provider have a National Provider Identifier (NPI) Number? ◯ **Yes** ◯ **No**

If "Yes," enter NPI. National Provider Identifier (NPI): ____________

(A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.)

4-Provider Contact Information *(Required for **EFT Only** or for **EFT & ERA** "Form Select" choice)*

Provider Contact Name:
(Name of contact in provider office for handling EFT issues)

Telephone Number:
(Associated with contact person)

E-mail Address:
(An electronic mail address at which the health plan might contact the provider)

4A-Provider Contact Information *(Required for **ERA Only** or for **EFT & ERA** "Form Select choice)*

Provider Contact Name:
(Name of contact in provider office for handling ERA issues)

Telephone Number:
(Associated with contact person)

E-mail Address:
(An electronic mail address at which the health plan might contact the provider)

5-Provider Agent Information *(If Applicable and you selected **EFT Only** or **EFT & ERA** "Form Select" choice)*

Provider Agent Name:
(Name of provider's authorized agent)

Provider Agent Contact Name:
(Name of contact in agent office for handling EFT issues)

Telephone Number:
(Associated with contact person)

E-mail Address:
(An electronic mail address at which the health plan might contact the provider)

5A-Provider Agent Information *(If Applicable and you selected **ERA Only** or **EFT & ERA** "Form Select" choice)*

Provider Agent Name:
(Name of provider's authorized agent)

Provider Agent Contact Name:
(Name of contact in agent office for handling ERA issues)

Telephone Number:
(Associated with contact person)

E-mail Address:
(An electronic mail address at which the health plan might contact the provider agent)

6-Financial Institution Information *(Required for **EFT Only** or for **EFT & ERA** "Form Select" choice)*

Financial Institution Name:
(Official name of the provider's financial institution)

Financial Institution Routing Number:
(A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited)

Type of Account at Financial Institution:
(The type of account the provider will use to receive EFT payment, e.g., Checking, Saving)

Provider's Account Number with Financial Institution:
(Provider's account number at the financial institution to which EFT payments are to be deposited)

Account Number Linkage to Provider Identifier. Select one option below.
(Provider preference for grouping [bulking] claim payments – must match preference for v5010 X12 835 advice)

◯ **Provider Tax Identification Number (TIN)** ◯ **National Provider Identifier (NPI)**

7-Electronic Remittance Advice Information *(Required for **ERA Only** or **EFT & ERA** "Form Select" choice)*

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)
(Provider preference for grouping [bulking] claim payment remittance advice – must match preference for EFT payment)

Does provider have a National Provider Identifier (NPI) Number? ◯ **Yes** ◯ **No**

Provider Tax Identification Number (TIN): ____________

(Required if NPI is not applicable)

National Provider Identifier (NPI): ____________

(Required if TIN is not applicable)

Method of Retrieval: ____________

(The method in which the provider will receive the ERA from the health plan [e.g., download from health plan website, clearinghouse, etc.])

8-Electronic Remittance Advice Clearinghouse Information *(Required for **ERA Only** or **EFT & ERA** "Form Select" choice)*

Clearinghouse Name: ____________

(Official name of provider's clearinghouse)

Clearinghouse Contact Name: ____________

(Name of a contact in the clearinghouse office for handling ERA issues)

Clearinghouse Telephone Number: ____________

(Telephone number of contact)

Clearinghouse E-mail Address: ____________

(An electronic mail address at which the health plan might contact the provider's clearinghouse)

9-Electronic Remittance Advice Vendor Information *(Required for **ERA Only** or **EFT & ERA** "Form Select" choice)*

Vendor Name: ____________

(Official name of provider's vendor)

Vendor Contact Name: ____________

(Name of a contact in vendor office for handing ERA issues)

Vendor Telephone Number: ____________

(Telephone number of contact)

Vendor Email Address: ____________

(An electronic mail address at which the health plan might contact the provider's vendor)

10-Submission Information *(Required)*

Reason for Submission: ◯ **New Enrollment** ◯ **Change Enrollment** ◯ **Cancel Enrollment**

Printed Name of Person Submitting Enrollment: ____________

(The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment)

Submission Date *(YYYYMMDD)*: ____________

(The date on which the enrollment is submitted)

Authorized Signature *(The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment)*.

☐ By signing below, provider acknowledges that the provider has read, agrees that it is subject to and agrees to comply with all terms and conditions, including those relating to the delivery of the services, which can be found at: https://view.echohealthinc.com/EFTERA/termandcondition.aspx.

Signature of Person Submitting Enrollment: ____________________

(A [usually cursive] rendering of a name unique to a particular person used as confirmation of authorization and identity)

Postal mail or e-mail completed form *(secure e-mail is recommended)* to ECHO Health, Inc. If by email send to: **EDI@EchoHealthinc.com**.

CLEAR PRINT