

**WHICH FORMS SHOULD I COMPLETE?**

Enrollments are handled at the TIN Level, so all associated NPIs to said TIN will be automatically enrolled.

There are multiple options for enrolling with ECHO, see below for details:

1. If you would like to enroll for **ERA only** you can either choose to enroll for each payer individually or enroll for 'all payers'.
  - a. You can submit a request by completing the **ECHO EFT/ERA Enrollment Form (pages 5-7)**
    - Follow instructions at the top of the form to ensure all sections are complete. There are no additional fees applied for the ERA Only Option.
      - If you are enrolling for only **Certain Payers**:
        - In the Payer/Insurance Company Name write the name of the payer from pages 3-4.
        - 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.
      - If you are enrolling for **All Payers**:
        - In the Payer/Insurance Company Name write "All Payers"
        - In Section 1- Form Select, choose "ERA Only"
    - Submit the form via update in the [EDI Support page](#). Choose ERA/835 Enrollment Only – Attachment Required. You can also choose the form(s) to email instead to [EDI@echohealthinc.com](mailto:EDI@echohealthinc.com)
2. If you would like to enroll for **EFT & ERA** you can either choose to enroll for each payer individually (no cost) or enroll for 'all payers' at a fixed cost.
  - a. If you are enrolling for only **Certain Payers**, you can submit a request by completing the **ECHO EFT/ERA Enrollment Form (pages 5-7)**
    - Follow instructions at the top of the form to ensure all sections are complete. There are no additional fees applied for the ERA Only Option.
      - In the Payer/Insurance Company Name write the name of the payer from pages 3-4.
      - 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.
    - In Section 1- Form Select, choose "EFT & ERA"
  - b. If you would like to enroll for **EFT & ERA** via the All Payer EFT program, you can complete the [enrollment online](#) but a 1.99% per payment charge will apply. If you need assistance, contact ECHO at [allpayer@echohealthinc.com](mailto:allpayer@echohealthinc.com)

## WHERE SHOULD I SEND THE FORM(S)?

Email To: [EDI@EchoHealthInc.com](mailto: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](mailto:EDI@EchoHealthInc.com)

**ONLY ONE PAYER CAN BE LISTED PER ENROLLMENT FORM**

Payer ID	Payer Name	Payer ID	Payer Name
72467	ACS Benefit Services	MIMCS	CareSource of Michigan Medicaid
128CA	Aetna Better Health of California	31114	CareSource of Ohio
128FL	Aetna Better Health of Florida	CAS89	CAS Coastal Administrative Services
68024	Aetna Better Health of Illinois	65391	CBHNP – Health Choice
26337	Aetna Better Health of Illinois MMAI	CHOC1	CHOC Health Alliance
128KS	Aetna Better Health of Kansas	CCA01	Central California Alliance for Health (CCAH)
128KY	Aetna Better Health of Kentucky	38219	Claimchoice Administrators (formerly AmeraPlan)
128LA	Aetna Better Health of Louisiana	85468	Clear Spring Health
128MD	Aetna Better Health of Maryland	77052	Coastal TPA (Coastal Administrative)
128MI	Aetna Better Health of Michigan	COACC	Colorado Access
46320	Aetna Better Health of New Jersey	35193	Community Health Alliance
128NY	Aetna Better Health of New York	27905	Community Health Alliance (TN)
50023	Aetna Better Health of Ohio	48145	Community Health Choice
23228	Aetna Better Health of Pennsylvania	45321	Consumers Choice Health Plan
66917	Aetna Better Health -Parkland (TX)	78375	Connecticare Medicare
28692	Aetna Better Health of Texas / TX Medicaid & CHIP	47165	Core Benefits
128VA	Aetna Better Health of Virginia	35182	CoreSource (AZ/IA/IL/IN/MD/MN/PA)
128WV	Aetna Better Health of West Virginia	48117	CoreSource KC (FMH)
13334	Affinity Health Plan	35187	CoreSource Internal
ALTAM	AltaMed	35183	CoreSource (OH)
20029	America’s Choice Healthplan	75136	CoreSource Little Rock
26119	American Insurance Administrators	58102	Covenant Administrators
44444	American Postal Workers Union (APWU)	39081	Custom Benefit Administrators
77013	AmeriHealth Caritas	82056	Custom Design Benefits
45408	AmeriHealth Caritas Next Florida	MCS03	Delano Regional Medical Group (MCS)
22248	AmeriHealth Caritas PA/Mercy Health Plan	37253	ELMCO (PHX)
64090	Amfirst insurance	37216	Employee Benefit Services
59274	AvMed, Inc.	37215	Employee Benefits Corporation
84323	Banner Medicare Advantage Plus PPO	45319	Evergreen Health
84324	Banner Medicare Advantage Prime HMO	59313	Evolution Healthcare
66901	Banner University Care LTC	94998	Firstcare (also enroll 94999)
88030	Baylor Scott and White Health Care Plan	94999	Firstcare Medicaid (also enroll 94998)
39081	Benefit Plan Administrators (WI)	25169	Gateway Health Plan - (Medicaid PA)
18768	Boulder Administration Services	60550	Gateway Health Plan - Medicare Assured
68011	Capitol Administrators	MCS03	GemCare Medical Group (MCS)
CARMO	Carelon Health – Palliative Care	95192	Group Health Cooperative Eau Claire
GACS1	CareSource of Georgia	25531	Group Health, Inc. HMO (Emblem)
KYCS1	Caresource of Kentucky	13551	Group Health, Inc. PPO (Emblem)
INCS1	CareSource of Indiana	47083	Group Management Services (GMS)
INCS1	CareSource Marketplace	64246	Guardian Life

**ONLY ONE PAYER CAN BE LISTED PER ENROLLMENT FORM**

Payer ID	Payer Name	Payer ID	Payer Name
MIMCR	HAP Caresource MI Health Link (Medicare-Medicaid Plan)	41124	Meritain Health
62111	Health Cost Solutions	38333	Molina Healthcare
80142	Health Partners Plans (PA)	37256	Mutual Assurance Administrators
HMA01	Healthcare Management Administrators	77076	Network Health Insurance (NHIC)
71063	HealthSCOPE Benefits	81264	Nippon Life Benefits
		88027	Northern Nevada Trust Fund (BPA)
37272	HealthSmart Benefit Solutions (JSL)	22321	One Call Medical
37283	HealthSmart Benefit Solutions (AA/GB)	OSCAR	Oscar Health
87815	HealthSmart Benefit Solutions (WF/AN)	04218	Pan American Life Insurance
55247	HIP Health Plan of NY	SLOS1	Physicians Choice Medical Group of San Luis Obispo
00257	Highmark Health	MCI01	Physicians Choice Medical Group of Santa Maria
47181	Highmark Health Options	55768	Piedmont Community Health Plan
74431	InHealth (Ohio PPO Connect)	37224	Pittman & Associates (HealthSmart Benefit)
IMSMS	Insurance Management Services	CB404	Preferred Health Plan of the Carolinas
51020	Integra Administrative Group	35174	QualChoice of Arkansas
RP075	Iowa Health Advantage	HMA01	Regence Group Administrators (RGA)
52189	John Hopkins Healthcare (52189 & 52123)	37278	ResourceOne
IP085	Kaweah Delta HC District Emp Plan	74205	Right Care from Scott & White
IP084	Kaweah Delta Medicare Advantage	50114	Sana Benefits
KELSE	Kelsey Seybold	72261	SCAN Health Plan
IP082	Key Medical Group	23285	Select Health of South Carolina
IP083	Key Medical Group - Medicare Advantage	87020	Sentinel Security Life Insurance Company
42344	Keystone First Community Health Choices	SIM02	SIMPRA Advantage
23284	Keystone Mercy Health Plan	A7637	Snedeker Risk Management (00381)
LSMA2	LaSalle Medical Associates	83245	Southwestern Health Resources
LCB01	Line Constructions Benefit Fund	25463	Surest (previously Bind)
01260	Magellan Behavioral Health	TKFMC	TKFMC
MCS03	Managed Care Systems (MCS)	TRP1E	Transamerica (TRP1E, TLINS, & TH071)
20805	Marrick Medical Finance	42137	TriStar
60230	Masonry Welfare Trust Fund	91078	Trusted Plans Service Corporation
04293	Mass General Brigham Health Plan	61425	Trustmark Insurance Company / Starmark
25160	MCA Administrators	74227	UHC Student Resources
39190	MedStar Family Choice	52180	UMWA Health & Retirement Funds
RP062	MedStar Family Choice DC	89070	United Concordia
RP063	MedStar Family Choice MD	TH023	WellMed Medical Management Inc.
22823	Med-American Benefits	93050	William C. Earhart Company
86052	Mercy Care Plan (AHCCCS)	62111	W.C Beeler & Company
33628	Mercy Maricopa Integrated Care/Mercy Care RBHA		

**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:** \_\_\_\_\_ **State/ Province:**  **ZIP Code/Postal Code:** \_\_\_\_\_  
*(City associated with provider address field)* *(ISO-3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.)* *(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:**  **E-mail Address:**   
(Associated with contact person) (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:**  **E-mail Address:**   
(Associated with contact person) (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:**  **E-mail Address:**   
(Associated with contact person) (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:**  **E-mail Address:**   
(Associated with contact person) (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 handling 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](mailto:EDI@EchoHealthinc.com).

**CLEAR**

**PRINT**