FIRST MEDICAL HEALTH PLAN (REFORM) (66064)
ERA-ENROLLMENT INSTRUCTIONS

WHICH FORMS SHOULD I COMPLETE?

- Change Healthcare ERA Enrollment Form
- Assertus Provider Enrollment Form
- First Medical EFT/ERA Authorization Form

WHERE SHOULD I SEND THE FORM(S)?

- Email all forms to batchenrollment@changehealthcare.com

WHAT IS THE TURNAROUND TIME?

- Standard Processing Time is approximately 14 days.

Send completed form to:
Batchenrollment@changehealthcare.com
Fax: (615) 885-3713

CHANGE HEALTHCARE

Remittance

Payer Information

CPID	Payer ID	Payer	Type	Est Days	Multi CH
7229	66064	FIRST MEDICAL HEALTHCARE (REFORM)	Professional	14	No

Special Enrollment Instructions

Vendor Information

Submitter ID	Submitter Name
330897513	Office Ally

Provider Information

Tax ID	NPI	Provider Number	Name		
Address			**City**	**State**	**Zip**
Contact Name				**Contact Phone**	
Contact Email Address					

Confirmation Addresses

Primary Email Address	Secondary Email Address

ERA Receiver

Distribution Detail

OFFALLEY

For Change Healthcare use only

 Last Revised Date: 07/27/21

assertus®
YOUR HEALTHCARE TECHNOLOGY PARTNER

PROVIDER ENROLLMENT
TRANSMISSION AUTHORIZATION

By completing and signing this authorization, the healthcare Provider is authorizing Assertus Holdings, LLC to interchange its electronic Healthcare transactions with the Trading Partner acting as a Delegate Transmission Site for the Healthcare Provider as reported hereunder.

Delegate Transmission Site	Site Account Number	NPI
CHC1	581651222	
Provider Name	Phone	Fax
Type ☐ Solo Practitioner ☐ Group Practice	Email	
Street Address	Postal Address ☐ Same as Street Address	
Off		

Notes:

Authorization

Hereby, I certify that I'm the Provider referenced above or an authorized representative and that the reported NPI on this form belongs to the Provider referenced above, and I authorize ASSERTUS Holdings, LLC for the interchange of related health care transactions thru the Delegate Transmission Site reported on this form. I understand that this authorization will remain active until canceled in writing. I also understand that it is my responsibility to monitor that every claims file submitted to Assertus has a positive confirmation receipt received and that I need to report to Assertus any missing confirmation receipts.

Billing Provider Authorized Signature	Date:	ASSERTUS Authorized Signature	Date:
Complete agreement, print, and obtain signature.			

First MEDICAL HEALTH PLAN, INC.

Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) Authorization Form

All fields must be completed. Forms with incomplete or invalid information cannot be processed.

Section I. Reason for Submission: Please select only one

- ☐ **New EFT Authorization**- Select the business line ☐ **Commercial** ☐ **GHP/Vital**
- ☐ **Request a Change**
- ☐ **EFT Cancellation-** Enclose a letter with a brief explanation of the cancellation reason.

Section II. Provider Information:

Provider Name:

IMC Provider Number: *If applicable*

Doing Business As (DBA) Name:

Provider Mailing Address:

Street:

City:

State:

PO Box:

Zip Code:

Provider Personal Contact Information:

Telephone Number:

Email Address:

Provider Identifiers:

Provider Federal Tax Identification Number (TIN):

National Provider Identifier (NPI):

Provider Contact Office Information:

Provider Contact Name:

Relation with the Provider:

Telephone Number:

Fax Number:

Email Address:

Clearinghouse Information:

Assigned Authority: Asserturs

Trading Partner ID: 581651222

Section III. Financial Institution Information:

Financial Institution Name:

Financial Institution Address:

Financial Institution Routing Number:		
Financial Institution Provider's Account Number:		
Financial Institution Provider's Account Type:	☐ **Checking Account**	☐ **Savings Account**

Section IV. Authorization and Signature:

I hereby authorize First Medical Health Plan, Inc., to initiate entire credits and/or adjustments for any duplicate or erroneous credits made to previously mentioned account. I hereby authorize the Financial Institution previously mentioned to make any credits and/or debits made by First Medical Health Plan, Inc., of the previously mentioned account. I understand that this authorization form will be part of the Terms and Conditions Agreement and will be included signed as part of this authorization form. I certify that the previously mentioned account is drawn in the name of the physician or individual practitioner or the legal business name of the provider or supplier. I certify that I sole control of the previously mentioned account in which First Medical Health Plan, Inc., will made the EFT deposits and that this account complies with all applicable Federal and State Laws and Regulations.

Printed Name of the person that submitting the EFT and ERA Authorization Form:

Printed Title of the person that submitting the EFT and ERA Authorization Form:

Provider Signature:	**Submission Date:**
Complete agreement, print, and obtain signature.	

Print

************************DO NOT WRITE BELOW THIS LINE************************

First Medical Health Plan, Inc., and International Medical Card, Inc., Internal Use

Receipt Date:	☐ ***Completed***	☐ ***Lack of Information***
Completion Date:	***Sending Notification Date:***	
Completed by:	***Sent by:***	

***** Please complete and signed this EFT and ERA Authorization Form and send it with the requested letters to First Medical Health Plan, Inc., at the address, fax or email provided in the Instructions to Complete and Send the EFT and ERA Authorization Form.**