FLORIDA HEALTHCARE PLANS (59322)
ERA ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- Availity Multi-Payer Electronic Remittance Advice Enrollment
- Send an email to EDISupport@fhcp.com with the following information:
    - **Subject:** ERA Enrollment Request
    - **Body of Email:**

      I am interested in receiving FHCP ERA's and the Availity ERA enrollment form has been submitted.

        - Provider Name
        - NPI
        - Tax ID

WHERE SHOULD I SEND THE FORM(S)?

- Email Availity ERA enrollment form to Autoreg835@availity.com; or
- Fax to (904) 470-4773; or
- Mail to:

  Availity LLC
  PO Box 550857
  Jacksonville, FL 32255-0857

WHAT IS THE TURNAROUND TIME FOR ENROLLMENT?

- Standard processing time is 7-10 business days.

HOW DO I CHECK STATUS?

- Email EDISupport@fhcp.com to check on the status of your enrollment.

Multi-Payer Electronic Remittance Advice Enrollment

Rev. 07.22.2015.1

PAYER INFORMATION	Refer to the Availity Health Plan Partner List for payer IDs.
Payer Name: Florida Health Care Plans	Payer ID: 59322
Payer Name:	Payer ID:
Payer Name:	Payer ID:
Payer Name:	Payer ID:
Payer Name:	Payer ID:

RECEIVER INFORMATION	* If different than provider contact information.
Who will receive your ERA files? ☐ Provider ☒ Clearinghouse ☐ Vendor	
Receiver Name: Office Ally	Availity Customer ID: 11904
Contact Name*: Customer Service	
Telephone Number*: (360) 975-7000 Ext: Opt 1	E-mail Address*: Support@officeally.com

PROVIDER INFORMATION			PROVIDER IDENTIFIERS INFORMATION
Provider Name:			Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):
Street:			
City:	State/Province:	ZIP Code/Postal Code:	National Provider Identifier (NPI):
Provider Name:			Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):
Street:			
City:	State/Province:	ZIP Code/Postal Code:	National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION	
Provider Contact Name:	
Telephone Number:	E-mail Address:

ELECTRONIC REMITTANCE ADVICE INFORMATION	
Preference for Aggregation of Remittance Data	☐ Provider Tax Identification Number (TIN):
	☐ National Provider Identifier (NPI):

SUBMISSION INFORMATION			
Reason for Submission:	☐ New Enrollment	☐ Change Enrollment	☐ Cancel Enrollment

Authorized Signature:

Important: By typing or signing a name in this field, you acknowledge and agree that you have been authorized by the provider or its agent to initiate, modify, or terminate an enrollment. You further acknowledge and agree that you have the legal authority to perform such action on behalf of your organization. In no event will Availity be liable for any losses or damages including without limitation, indirect or consequential losses or damages, or any loss or damage whatsoever arising from loss of data or profits arising out of, or in connection with this submission.

Printed Name of Person Submitting Enrollment:	Submission Date:

SEND THE FORM VIA:	E-mail: E-mail Form	Fax: 904.470.4773	Mail: Avality LLC P.O. Box 550857 Jacksonville, FL 32255-0857