



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

Registration with Office Ally at officeally.com is required to receive an ERA from HSM.

A. CLINIC INFORMATION - ALL FIELDS REQUIRED										
Clinic Name:	_____									
Clinic Tax ID:	_____ Clinic NPI _____									
Office Ally User Name	_____									
B. CONTACT INFORMATION - ALL FIELDS REQUIRED										
Contact Name:	_____									
Phone:	_____ Fax: _____									
Email:	_____									
C. PAYMENT METHOD										
Paper Check <input type="checkbox"/>	Electronic Funds Transfer (EFT) <input type="checkbox"/> If EFT is selected please complete SECTION D									
D. BANK INFORMATION - Required Only if EFT payment method is selected.										
Bank Name:	_____									
Bank Routing Number (9 Digits)	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>									
Account Number:	_____									
Account Type:	Savings <input type="checkbox"/> Checking <input type="checkbox"/>									
A voided check is required with EFT enrollment. Please fax copy of check with enrollment form. To be eligible for EFT from HSM your office must be setup for Electronic Remittance Advice.										
E. AUTHORIZED SIGNATURE										
Signature:	_____									
Print Name:	_____									
Title:	_____									
Date:	_____									

Please fax completed form to HSM ERA Enrollment at 651-501-9644

This form will certify that Office Ally is authorized to receive the ERA for the clinic tax ID listed. Contact HSM Provider Services at 800-432-3640 with questions regarding your enrollment.