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

Magellan Healthcare provides the convenience of Electronic Remittance Advice (ERA/835) and Electronic Funds Transfer (EFT) to all of our providers. We encourage you to take advantage of this service by completing the attached form.

When completing the form, please follow these guidelines:

- ✓ ERA & EFT enrollment is by Clinic Tax ID (or EIN). Please enter the legal clinic name as the *Provider Name*.
- ✓ Include your TIN and your payee NPI. Both fields are required for processing.
- ✓ Use *Assigning Authority* to identify how you will receive the ERA/835. This is either **Office Ally** or the name of the clearinghouse that partners with Office Ally to receive 835 files. Alternatively you can opt to view your remits through our secure website (www.hsminc.com) by indicating **Magellan Website** in this field.
- ✓ Use *Trading Partner ID* to indicate your Office Ally username. This is a required field only if you are receiving your remits through Office Ally.
- ✓ Include a pre-printed voided check or letter from your bank to verify your EFT payment information.

Please fax the completed form to Magellan ERA enrollment at 888-656-1913.

Completing and submitting the attached form will certify that the indicated clearinghouse is authorized to receive the ERA/835 for the clinic tax ID listed.

Contact Magellan Healthcare Provider Services at 800-432-3640 with questions regarding your enrollment.

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

Magellan HEALTHCARE SM

PROVIDER INFORMATION

Provider Name: _____

Doing Business As Name (DBA): _____

PROVIDER IDENTIFIERS INFORMATION

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

National Provider Identifier (NPI): _____

Assigning Authority: _____ Trading Partner ID: _____

Provider Contact Name: _____

Telephone Number: _____ Fax Number: _____

Email address: _____

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name: _____

Financial Institution Routing Number: ☐☐☐☐☐☐☐☐☐

Type of Account at Financial Institution: Savings ☐ Checking ☐

Provider's Account Number with Financial Institution: _____

SUBMISSION INFORMATION

Reason For Submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Include with Enrollment Submission: ☐ Bank Letter ☐ Voided Check

Authorized Signature: _____

Printed Name of Person Submitting Enrollment: _____

Printed Title of Person Submitting Enrollment: _____

Submission Date: _____