HEALTH NET (CA/OR)
ERA ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- **Health Net Electronic Remittance Advice (ERA) Authorization Agreement**

WHERE SHOULD I SEND THE FORM(S)?

- Save and email to setup@abilitynetwork.com; OR
- Fax to (888) 999-8670

WHAT IS THE TURNAROUND TIME?

- Please allow 3 weeks for the registration process to be completed. If after 4 weeks you do not start receiving ERAs, please call Health Net's EDI team at 1-800-641-7761 .

HOW DO I CHECK STATUS?

- To check the status of the Health Net Electronic Remittance Advice (ERA) Authorization Agreement, please call Health Net's EDI team at 1-800-641-7761 .
- Upon registration completion, paper remits will be generated along with the ERA for the first 30 days, after which paper remits will CEASE while ERA transmissions continue. For questions, contact payer at (800) 977-3568.

Health Net of CA

Health Net

Health Net of California Electronic Remittance Advice (ERA) Authorization Agreement

OA

Provider Information

Provider Name ______________________________

Provider Address Street ______________________________

City ____________________ State ____________________ Zip ____________________

Provider Identifiers Information

Provider Identifiers

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) ____________________

National Provider Identifier (NPI) ____________________

Provider Contact Information

Provider Contact Name ______________________________ Telephone Number ____________________

Email Address ______________________________ Fax Number ______________________________

Provider Agent Information

Provider Agent Name ______________________________

Telephone Number______________________________ Email Address______________________________

Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider).

O Provider Tax Identification Number (EIN) ____________________

O National Provider Identification Number (NPI) ____________________

Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name MD On-Line Inc.

Telephone Number (888) 499-5465 Email Address setup@abilitynetwork.com

Electronic Remittance Advice Vendor Information

Vendor Name ______________________________

Telephone Number______________________________ Email Address______________________________

Submission Information

Reason for Submission: O New Enrollment O Change Enrollment O Cancel Enrollment

Authorized Signature:

Printed Signature of Person Submitting Enrollment ______________________________

Submission Date ____________________ Requested ERA Effective Date ____________________

This authorization is to remain in effect until written notice in the form of an ERA Authorization Agreement form marked as a cancellation or change form is submitted to Health Net. Any changes to the providers agent, clearinghouse or vendor must be submitted on an ERA Authorization Agreement form as a change. The termination or change shall be effective 20 days subsequent to Health Net's receipt of the updated form.