HEALTH NEW ENGLAND (04286)
ERA ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- **Optum 835 Enrollment Request**
- **Change Healthcare Remittance Form**
    - *You only need to fill out the form for the form type you are using (Professional or Institutional)*
- **Health New England 835 Healthcare ERA Request & Compensation (EFT) Enrollment Form**

WHERE SHOULD I SEND THE FORM(S)?

- Email ALL forms to OptumERA@officeally.com
- Email the Health New England form to penrollment@hne.com; OR fax to (413) 233-2665
- Email the Change Healthcare and Health New England forms to batchenrollment@changehealthcare.com

WHAT IS THE TURNAROUND TIME?

- Standard processing time is 15-30 business days.

HOW DO I CHECK STATUS?

- To check your enrollment status, send an email to support@officeally.com

OPTUM 835 ENROLLMENT REQUEST

Email this form to Support@officeally.com or Fax to (360) 896-2151. Once your form is received and processed, Office Ally will email you a confirmation. If you do not receive a confirmation email from us within 2-3 business days or faxing or emailing this form, please send it again. Please make sure to print legibly and to complete this form in its entirety. You risk delaying enrollment if the application is unreadable or incomplete. All fields in **bold** are **required.**

PROVIDER INFORMATION

Provider Name:

Provider Address: **City:** **State:** **Zip:**

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number
Employer Identification Number (EIN): **National Provider Identifier (NPI):**

PROVIDER CONTACT INFORMATION

Contact Name: **Telephone Number/Extension:**

Email Address: **Fax Number:**

SUBMISSION INFORMATION

Reason for Submission: New ERA Enrollment

Authorized Signature:

Note: Electronic Signature (Typed Name) of Person Submitting ERA Enrollment.

Submit by Email

Clear Form

NOTE: If you have received ERA's from these payers through another clearinghouse, you may be prompted via email from your previous clearinghouse to confirm the change. If you do not confirm the change, enrollment will be delayed.

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
6432	04286	HEALTH NEW ENGLAND	Professional	14	No

Special Enrollment Instructions

Claims must be sent before remittance can be setup.

Vendor Information

Submitter ID	Submitter Name
332211888	AVAILITY LLC

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
aacenrollment@availity.com	

ERA Receiver

Distribution Detail

AVAILITY

For Change Healthcare use only

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
9638	04286	HEALTH NEW ENGLAND	Institutional	14	No

Special Enrollment Instructions

Claims must be sent before remittance can be setup.

Vendor Information

Submitter ID	Submitter Name
332211888	AVAILITY LLC

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
aacenrollment@availity.com	

ERA Receiver

Distribution Detail
AVAILITY

For Change Healthcare use only

Health New England
One Monarch Place, Suite 1500
Springfield, MA 01144-1500
healthnewengland.org

835 HEALTHCARE ELECTRONIC REMITTANCE ADVICE (ERA) REQUEST & COMPENSATION ELECTRONIC FUNDS TRANSFER (EFT) ENROLLMENT FORM

Fax: 413.233.2665 or Email: penrollment@hne.com

If you would like to submit this form through our website, please click link to go to: https://www.hnedirect.com/eft/EFTPage1.aspx.
***Indicates required fields within each section. Incomplete and/or illegible fields may cause your enrollment to be delayed.**

SELECT AN ENROLLMENT TYPE	ERA ONLY	EFT ONLY	BOTH ERA & EFT
NEW ENROLLMENT	☐	☐	☐
CHANGE TO ENROLLMENT	☐	☐	☐
CANCEL ENROLLMENT	☐	☐	☐

SECTION A - PROVIDER/GROUP/FACILITY INFORMATION

PLEASE SELECT THE OPTION(S) THAT APPLY

☐ INDIVIDUAL PROVIDER ☐ GROUP/PRACTICE ☐ FACILITY ☐ BOTH GROUP & FACILITY

*PROVIDER/GROUP/FACILITY NAME

*PROVIDER TAX ID (MULTIPLE TAX IDs SEE ATTACHMENT 1) (TAX FIELDS MUST CONTAIN 9 DIGITS)

PROVIDER NPI (NPI FIELDS MUST CONTAIN 10 DIGITS)

*PROVIDER CONTACT NAME

*PROVIDER CONTACT PHONE NUMBER

*PROVIDER CONTACT EMAIL

*PROVIDER BILLING ADDRESS

*CITY

*STATE

*ZIP

SECTION B - VENDOR INFORMATION/CLEARINGHOUSE/BILLING AGENT (IF YOU ARE USING A VENDOR THE FOLLOWING INFORMATION IS REQUIRED. CLICK HERE TO SEE LIST OF VENDORS.)

VENDOR NAME: Change Healthcare

VENDOR TAX ID: 133052274

VENDOR CONTACT PHONE NUMBER: 866-924-4634

☐ BY CHECKING HERE, PROVIDER AUTHORIZES HEALTH NEW ENGLAND, INC. TO TRANSMIT PROVIDER'S 835 FILES TO VENDOR.

PROVIDER, _____, HEREBY APPOINTS Change Healthcare,
PROVIDER NAME/PROVIDER REPRESENTATIVE NAME (PLEASE PRINT) *VENDOR NAME (PLEASE PRINT)*

TO ACT AS THE AUTHORIZED AGENT FOR THE PURPOSE OF RETRIEVING THE 835 ERA ELECTRONICALLY FROM HEALTH NEW ENGLAND, INC.

SECTION C - ERA ACKNOWLEDGMENT

Providers who choose to receive 835 transactions directly from HNE may elect to return a 999 Acknowledgement file. HNE does not require this but if you do opt in, you must always transmit the acknowledgement file.

☐ Please check here if you will be sending an 999 Acknowledgement file.

SECTION D - PROVIDER CERTIFICATION

THE UNDERSIGNED PROVIDER, _____,
PROVIDER NAME (PLEASE PRINT)

HEREBY CERTIFIES TO HEALTH NEW ENGLAND, INC. THE FOLLOWING WITH RESPECT TO THE 835 ELECTRONIC REMITTANCE ADVICE:

- Provider will coordinate receipt of remittance test file(s) from the designated clearinghouse/vendor if a vendor is named.
- Provider acknowledges that it will complete the test file(s) and use the 835 ERA data for posting to their accounting systems.
- Provider will notify their EDI Vendor of their intention to begin ERA testing.
- Provider agrees that upon approval of this Certification and the initiation of routine ERA processing, Provider will no longer receive a hard copy EOR (Explanation of Remittance) after thirty (30) days from production.
- Provider, or an authorized representative of Provider, will notify Health New England, Inc. in writing of any changes or corrections required in the ERA process.

(Continue to the next page).

SECTION E - EFT/FINANCIAL INSTITUTION

New EFT enrollments or changes to existing EFT banking information will take **up to** fifteen business days to complete.
New ERA enrollments or changes to existing ERA information will take **up to** thirty-five business days to complete.

*FINANCIAL INSTITUTION/BANK NAME			
*NAME AS IT APPEARS ON BANK ACCOUNT			
*BANK ADDRESS	*CITY	*STATE	*ZIP
*TYPE OF BANK ACCOUNT ☐ CHECKING ☐ SAVINGS	*BANK ROUTING NUMBER	*BANK ACCOUNT NUMBER	

SECTION F - CHANGE/CANCEL ENROLLMENT

IF YOU ARE REQUESTING AN EFT CHANGE (YOUR BANK AND/OR BANK ACCOUNT NUMBER), THE FOLLOWING INFORMATION IS REQUIRED:

*PREVIOUS BANK NAME			
*PREVIOUS BANK ADDRESS	*CITY	*STATE	*ZIP
*TYPE OF BANK ACCOUNT ☐ CHECKING ☐ SAVINGS	*PREVIOUS BANK ROUTING NUMBER	*PREVIOUS BANK ACCOUNT NUMBER	

SECTION G - PROVIDER AUTHORIZATION/SIGNATURE

The undersigned Provider hereby authorizes and requests Health New England, Inc. (HNE) to effect payment for all amounts owed to the Provider by HNE as such amounts become payable. Payment shall be made by initiating entries to the Provider's account in the bank or financial institution indicated above. The Provider authorizes and requests said bank or financial institution to credit the same to such account.

This authorization is active as of two weeks after HNE receives the request and shall remain in effect until terminated. The Provider may terminate this authorization without cause by giving 15 days prior written notice to HNE. HNE may terminate this authorization without cause at any time.

I agree that if unearned or erroneous payment is credited to my account by HNE, I will immediately repay HNE the full amount of such unearned or erroneous pay. I also agree to allow an automatic reversal of any deposits made in error.

AUTHORIZED REPRESENTATIVE SIGNATURE ⓧ	PRINT TITLE
PRINTED NAME OF AUTHORIZED REPRESENTATIVE	DATE
AUTHORIZED REPRESENTATIVE PHONE NUMBER	AUTHORIZED REPRESENTATIVE EMAIL

ATTACHMENT 1 - MULTIPLE TAX IDs

Please complete this section only if you need to list additional Tax IDs that are in addition to the one listed in Section A.

FACILITY/GROUP/PRACTICE/PROVIDER NAME	TAX ID (TAX FIELDS MUST CONTAIN 9 DIGITS)	NPI (NPI FIELDS MUST CONTAIN 10 DIGITS)	BILLING ADDRESS