HEALTHCARE PARTNERS MEDICAL GROUP
ERA & EFT ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- 835 Enrollment Request
- Electronic Funds Transfer Request
    - *Include a voided check with the EFT enrollment request*

WHERE SHOULD I SEND THE FORM(S)?

- ERA Enrollment: Fax form to (310) 352-6219
- EFT Enrollment: Email form to brossato@healthcarepartners.com

WHAT IS THE TURNAROUND TIME FOR ERA ENROLLMENT?

- Standard processing time is 10-14 business days

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835 Enrollment Request

Type of Request:

- ☐ ***NEW*** (Check if not currently receiving an Electronic 835 Remit. Complete section 1 & 2)
- ☐ ***Change*** (Check if the delivery path of the 835 is being changed from a different receiver Complete sections 1,2, and 3)
- ☐ ***Delete*** (Check if terminating receipt of the 835. Complete sections 1 and 4.)

Please fax completed form to DaVita-HCP ATTN: Technical Services – EDI (310) 352-6219

1. Healthcare Professional / Institution Information		
Contact Name	Contact Number	
Contact Email	Prov / Inst Group NPI #	
HealthCare Prof/Inst Name	TIN	
Address	Phone	
City	State	Zip

2. Receiver Information		
Receiver Name	Office Ally, Inc.	
Contact	Customer Service	
Telephone	360-975-7000 Option 1	DaVita-HCP Submitter ID

3. Change Enrollment (Current/Old receiver)
Receiver Name
Change Enrollment for:
Target date for completion (Date will be no more than 15 days from enrollment date at DaVita-HCP):

4. Delete Enrollment
Receiver Name
Delete Enrollment for (DaVita-HCP use Only):

5. DaVita-HCP / MCA – System Update
MCA Analyst Name:
Date Completed:
Paper EOB process will cease after 45 days

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ELECTRONIC FUNDS TRANSFER REQUEST

To sign up for Electronic Funds Transfer (EFT), please complete all of the information below.

Date: _____

Provider/Institution:_____

Provider/Institution TIN: _____

Provider/Institution E-mail Address:_____

Bank Name: _____

Bank Routing Number:_____

Bank Account Number:_____

Signature Authorizing Funds Transfer:_____

Contact Phone number for questions:_____

***** With this form, please include a voided or copy of a check from the bank account into which you would like the funds transfer routed.**
***** Please email this form and the voided or copy of a check to Barbara Rossato at: brossato@healthcarepartners.com.**

For any questions/issues you may have, please contact Barbara Rossato at (310) 354 – 4377.