

HEALTHCHOICE OF OKLAHOMA (22521) ERA ENROLLMENT INSTRUCTIONS



WHICH FORM(S) SHOULD I DO?

- [Emdeon EnrollNow \(Click here\)](#)
 - **NOTE:** This is completed online.
 - Office Ally supports only the payers listed on the Emdeon ERA Enrollment form below. Do not choose payers that are listed on the Emdeon ERA Enrollment form when completing the EnrollNow online form.
- Emdeon ERA Enrollment Form
- Electronic Remittance Advice (ERA) Authorization Agreement

WHERE SHOULD I SEND THE FORM(S)?

- **Emdeon EnrollNow** is completed online
 - **NOTE:** If the payer you're enrolling for is not listed on this webpage, just enter the provider information and click Submit. The payer information will be entered on the Emdeon ERA Enrollment form.
- **Emdeon ERA Enrollment Form**
 - Save and email the form to support@officeally.com
 - Make sure that the email subject is: **Emdeon ERA Enrollment**
- **Electronic Remittance Advice (ERA) Authorization Agreement**
 - Save and email the form to EGID.NetworkManagement@omes.ok.gov

WHAT IS THE TURN AROUND TIME?

- Once Office Ally receives your **Emdeon ERA Enrollment Form**, we will process the request within 24-48 hours.
- The payer will process your request within 14 business days.

EMDEON ERA ENROLLMENT FORM



In order to enroll to receive ERAs electronically from this payer, please fill out this form and return it via email to Support@officeally.com, the Email Subject should read: **Emdeon ERA Enrollment**.

PAYER INFORMATION OF THE PAYER YOU ARE ENROLLING FOR ERAS FROM:

PROVIDER INFORMATION:

Provider Name:

Provider Address:

PROVIDER IDENTIFIERS INFORMATION:

**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:

ELECTRONIC REMITTANCE ADVICE INFORMATION:

**Preference for Aggregation
of Remittance Data:**

Note: Account Number Linkage to Provider Identifier. Must match preference for EFT payments.

SUBMISSION INFORMATION:

Reason for Submission:

Authorized Signature:

Note: Electronic Signature (typed name) of Person Submitting ERA Enrollment.

Electronic Remittance Advice (ERA) Authorization Agreement

Provider Information

Provider Name: _____

Doing Business As Name (DBA): _____

Provider Address

Street: _____

City: _____ State/Province: _____ ZIP Code/Postal Code: _____

Provider Identifiers Information

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

National Provider Identifier (NPI) _____ Provider Type: _____

Electronic Remittance Advice Information

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

Provider Tax Identification Number (TIN): _____

National Provider Identifier (NPI): _____

Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name: _____

Clearinghouse Contact Name: _____ Telephone Number: _____

Submission Information

Reason for Submission

New Enrollment

Change Enrollment

Cancel Enrollment

Authorized Signature

I hereby authorize the Office of Management and Enterprise Services (OMES) Employees Group Insurance Department (EGID) to send electronic remittance advice (ERA/835) as designated herein. I am authorized to elect Electronic Remittance Advice (ERA) transactions on behalf of the indicated party and I acknowledge the same by signing below.

Written Signature of Person Submitting Enrollment: _____

Printed Name of Person Submitting Enrollment: _____

Printed Title of Person Submitting Enrollment: _____

Submission Date: _____