HEALTHCOMP (85729)
ERA ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- Electronic Remittance Advice (ERA) Authorization Agreement
- Electronic Funds Transfer (EFT) Authorization Agreement

WHERE SHOULD I SEND THE FORM(S)?

- Fax form to (559) 499-2464

WHAT IS THE TURNAROUND TIME FOR ENROLLMENT?

- Standard processing time is 3-4 weeks

HOW DO I CHECK STATUS?

- For questions regarding the form or to check status, please contact HealthComp at (559) 499-2450.

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Electronic Remittance Advice (ERA) Authorization Agreement

Provider Information

Provider Name _____

Provider Street Address _____

City _____ State _____ Zip _____

Provider Identifier Information

Provider Federal Tax Identification Number (TIN)_____

National Provider Identifier (NPI) _____

Provider Contact Information

Provider Contact Name _____ Title _____

Telephone Number _____ Fax Number _____

Email Address _____

Electronic Remittance Advice Information

Please indicate how you would like your claim payment remittance advices (ERA's) grouped: *

(Choose One)

O by Provider Tax Identification Number (TIN): ☐

O by National Provider Identification Number (NPI): ☐

* ***NOTE***: *This must match the preference selected on your EFT enrollment form.*

Electronic Remittance Advice Clearinghouse Information *

Clearinghouse Name Office Ally

Telephone Number 360-975-7000 Option 1 Email Address Support@officeally.com

** If other than Office Ally, please include the attached authorization letter with your enrollment form.*

Electronic Remittance Advice Vendor Information (if applicable)

Vendor Name _____

Telephone Number_____ Email Address_____

Submission Information

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

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Printed Name of Person Submitting Enrollment _____

Authorized Signature _____

Submission Date _____ Requested ERA Effective Date _____

This authorization will remain in effect until an ERA Authorization Agreement form marked as 'cancel enrollment' or 'change enrollment' is submitted to HealthComp. Any changes to the provider's clearinghouse or vendor must be submitted on an ERA Authorization Agreement form. The termination or change shall be effective 20 days after HealthComp's receipt of the updated form.

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Instructions for completing the ERA Registration form

- Please type or print legibly.
- Use only black or blue ink to complete form.
- Please allow 3 weeks for registration process to be completed. If after 4 weeks you do not start receiving ERA's then you may contact HealthComp at 559-499-2450.
- **For questions about this form, please call 559-499-2450**

Provider Information

- **Provider Name:** Please fill out completely.
- **Provider Address:** Complete legal name of institution, corporate entity, practice or individual provider.
- **Street:** The number and street name where a person or organization can be found.
- **City:** City associated with provider address field.
- **State:** Character code associated with the state. 2 digits.
- **Zip Code:** Postal zone code.

Provider Identifier Information

- **Provider Federal Tax Identification Number (TIN):** Federal tax identification number used to identify a business. 9 digits.
- **National Provider Identifier (NPI):** HIPAA unique provider identifier. 10 digits.

Provider Contact Information

- **Provider Contact Information:** Enter the name of the person, title, phone/fax number and e-mail address of the person authorized to provide information that relates to electronic remittance advices.

Electronic Remittance Advice Information

- **Preference for Grouping of Remittance Data:** This must match the preference on the EFT enrollment form. Select one option and provide the number:

  - **By Provider Tax Identification Number (TIN):** Federal tax identification number (TIN). Numeric, 9 digits
  - **By National Provider Identifier (NPI):** Unique identification number for covered healthcare providers. Numeric, 10 digits

Clearinghouse Information

- **Clearinghouse Name:** Official name of the provider's clearinghouse.
- **Telephone Number:** Telephone number for clearinghouse contact.
- **Email Address:** Email address for clearinghouse contact.

Vendor Information (if applicable)

- **Vendor Name:** Official name of the provider's vendor.
- **Telephone Number:** Telephone number for vendor contact.
- **Email Address:** Email address for vendor contact.

Submission Information:

- **New Enrollment:** Enrollment of new ERA account.
- **Change Enrollment:** This information facilitates the registration transition from an old to a new clearinghouse and expedites processing your change.
- **Cancel Enrollment:** Use to terminate receipt of electronic remittance advice data.

- **Printed Name of Person Submitting Enrollment:** Printed name of preparer or responsible individual.
- **Authorized Signature:** Signature of preparer or responsible individual.
- **Submission Date:** Enter the date submitted for enrollment.
- **Requested ERA Effective Date:** This is the date the provider wishes to begin receiving ERA data.

Fax the completed form to: 1-559-499-2464

****IMPORTANT****: HealthComp uses a clearinghouse named Office Ally to deliver provider ERA's. If you will be using a clearinghouse OTHER THAN Office Ally to receive ERA's, please provide the following information and include it with your HealthComp ERA enrollment form. This letter will authorize Office Ally to direct your electronic remittance advices to the clearinghouse indicated on your HealthComp ERA enrollment form. Fax the completed ERA enrollment form and this Office Ally authorization letter to 559-499-2464.

PRINT ON PROVIDER LETTERHEAD

ENTER DATE

Office Ally, LLC
Fax: 360-896-2151

RE: ERA Linking Letter

To Whom It May Concern:

I hereby authorize Office Ally to link any and all of Enter Provider/Group Name's 835/ERA transactions for the Tax ID(s) and NPI(s) listed below to account/username: Office Ally Username / Clearinghouse Name.

Tax ID(s): _____

NPI(s): _____

Please move all ERAs over to this new account as of: **XX/XX/XXXX [Enter Date]**

I certify that I am an authorized individual for the Tax ID(s) and NPI(s) listed above.

Thank you,

[Authorized Signature] – Owner of Practice/Provider/CEO/CFO/ COO

[Printed Name AND Title]

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Electronic Funds Transfer (EFT) Authorization Agreement

Provider Information

Provider Name _____

Provider Street Address _____

City _____ State _____ Zip _____

Provider Identifier Information

Provider Federal Tax Identification Number (TIN)_____

National Provider Identifier (NPI) _____

Provider Contact Information

Provider Contact Name _____ Title _____

Telephone Number _____ Fax Number _____

Email Address _____

Financial Institution Information

Financial Institution Name _____

Financial Institution Routing Number _____

Provider's Account Number with Financial Institution_____

Type of Account at Financial Institution: **O** Checking **O** Savings

Please indicate how you would like your claim payments (EFT's) grouped: *

(Choose One)

O by Provider Tax Identification Number (TIN): | |

O by National Provider Identification Number (NPI): | |

* ***NOTE***: *This must match the preference selected on your ERA enrollment form.*

Submission Information

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

Include with Enrollment Submission: **O** Voided Check **O** Bank Letter

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Printed Name of Person Submitting Enrollment _____

Authorized Signature _____

Submission Date _____ Requested EFT Start/Change/Cancel Date _____

Provider expressly authorizes HealthComp to initiate credit entries (or, if necessary, debit entries and adjustments for any credit entries made in error) to the above-referenced bank account number. Provider accepts responsibility for any resulting loss of payment and releases HealthComp of any liability for or arising from provider's failure to submit accurate or updated information to HealthComp relating to the bank account. This authorization will remain in effect until an EFT Authorization Agreement form marked as 'cancel enrollment' or 'change enrollment' is submitted to HealthComp. The termination or change shall be effective 10 days after HealthComp's receipt of the updated form.

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Instructions for Completing the EFT Registration Form

- Please type or print legibly.
- Use only black or blue ink to complete form.
- Please allow 4 weeks for registration process which includes pre-note verification. If after 4 weeks you do not start receiving payment via EFT, then you may contact HealthComp at 559-499-2450.
- **For questions about this form, please call 559-499-2450.**

Provider Information

- **Provider Name:** Please fill out completely.
- **Provider Address:** Complete legal name of institution, corporate entity, practice or individual provider.
- **Street:** The number and street name where a person or organization can be found.
- **City:** City associated with provider address field.
- **State:** Character code associated with the state. 2 digits.
- **Zip Code:** Postal zone code.

Provider Identifier Information

- **Provider Federal Tax Identification Number (TIN):** Federal tax identification number used to identify a business. 9 digits.
- **National Provider Identifier (NPI):** HIPAA unique provider identifier. 10 digits.

Provider Contact Information

- **Provider Contact Information:** Enter the name, title, phone/fax number and e-mail address of the person authorized to provide information that relates to EFT payments or inquiries.

Financial Institution Information

- **Financial Institution Name:** Enter the designated financial institution name.
- **Financial Institution Routing Number:** Enter the bank routing transit number.
- **Provider Account Number with Financial Institution:** Enter the bank account number (not to exceed 17 digits).
- **Type of Account at Financial Institution**: Indicate whether the account your EFT payments will be deposited to is a checking or savings account. Check only one box.
- **Preference for Grouping of Remittance Data:** This must match the preference on the ERA enrollment form. Select one option and provide the number:
    - **By Provider Tax Identification Number (TIN):** Federal tax identification number (TIN). Numeric, 9 digits
    - **By National Provider Identifier (NPI):** Unique identification number for covered healthcare providers. Numeric, 10 digits

Reason for Submission

- **New Enrollment:** Enrollment of new EFT account.
- **Change Enrollment:** This information facilitates the registration transition from an old to a new bank account and expedites processing your bank account change.
- **Cancel Enrollment:** Use to terminate receipt of EFT payments.
- **Include with Submission:** Please include a copy of a voided check if checking account is being used.

Authorization

- **Printed Name of Person Submitting Enrollment:** Printed name of preparer or responsible individual.
- **Authorized Signature:** Signature of preparer or responsible individual.
- **Submission Date:** Enter the date submitted for enrollment.
- **Requested EFT Start/Change/Cancel Date:** Date for the requested action to become effective.

Fax the completed form to: 1-559-499-2464

NOTE*: The provider must contact its financial institution to arrange for the delivery of the CORE required Minimum CCD+ data elements needed for reassociation of the payment and the ERA. See Phase III CORE EFT & ERA Reassociation (CCD+/835) Rule Version 3.0.0.*