HEALTHFIRST (80141)
ERA ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- Emdeon ERA Enrollment Form
- Healthfirst EFT Authorization Form
    - **NOTE**: Providers must enroll for EFT in order to receive ERAs.

WHERE SHOULD I SEND THE FORM(S)?

- **Emdeon ERA Enrollment Form:**
    - Save and email to Support@officeally.com
    - Make sure that the email subject is **Emdeon ERA Enrollment**
- **Healthfirst EFT Authorization Form:** Once completed, mail/fax/email form to:

    Provider Operations and Reimbursement
    P.O. Box 5168
    New York, NY 10274-5168
    EMAIL: HFPROVSRVS@Healthfirst.org
    Fax: 1-646-313-4635

WHAT IS THE TURNAROUND TIME?

- Once Office Ally receives your **Emdeon ERA Enrollment Form**, we will process the request within 24-48 hours.
- The time it takes ERAs to start coming through is dependent upon that individual payer. Generally, ERAs can take anywhere from 14 to 45 days to begin coming through.

HOW DO I CHECK THE STATUS OF MY ERA ENROLLMENT?

- To check the status of the **835 Enrollment Request Form**, please email or call Office Ally's Customer Suport Department at support@officeally.com or (360) 975-7000 option 1.
    - Make sure to provide the **Payer, TIN/EIN** and **NPI** that was submitted on the form when you contact us.

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 NAME AND PAYER ID:

HEALTHFIRST - PAYER ID 80141

PROVIDER INFORMATION:

Provider Name:

Provider Address:

PROVIDER IDENTIFIER 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: Select One

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

SUBMISSION INFORMATION:

Reason for Submission: New ERA Enrollment

Authorized Signature:

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

healthfirst®
Health Insurance for New Yorkers

Electronic Funds Transfer (EFT) Authorization Agreement

An asterisk (*) indicates required fields within each section. Incomplete and/or illegible fields and signatures will cause your enrollment to be delayed. Refer to instructions before completing this form.

PROVIDER INFORMATION

*Provider Name	Trading Partner ID (Healthfirst Provider ID)
*Provider Street Address	*City *State *ZIP Code

PROVIDER IDENTIFIERS INFORMATION

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

*Provider Type

☐ Ancillary ☐ Hospital ☐ Physician ☐ Physician Group ☐ Other _____

PROVIDER CONTACT INFORMATION

*Provider Contact Name	*Title
*Telephone Number	*Email Address

FINANCIAL INSTITUTION INFORMATION

I hereby authorize Healthfirst, called COMPANY, to initiate credit entries and, if necessary, adjustments for any credit entries to the account indicated below and the depository named below, hereafter called DEPOSITORY, to credit the same to such account.

*Financial Institution Name	*Name on Account with Financial Institution
*Financial Institution Routing Number	*Type of Account at Financial Institution ☐ Checking ☐ Savings
*Provider's Account Number with Financial Institution	*Account Number Linkage to Provider Identifier ☐ Provider Federal Tax Identification Number (TIN)

SUBMISSION INFORMATION

*Reason for Submission

☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

AUTHORIZATION AGREEMENT AND SIGNATURE

The undersigned hereby certifies that the information provided herein is true and accurate and that he/she has been authorized by PROVIDER to execute this agreement on behalf of PROVIDER to form a legally binding contract, and understands that acceptance of this Agreement constitutes an agreement to be bound to perform in strict conformity with all contracts between PROVIDER and COMPANY, and all applicable laws and regulations. This Authorization remains in full force and effect until COMPANY has received written notification from PROVIDER's duly authorized representative(s) of PROVIDER's termination. Such notification shall be provided in writing and in enough time to provide the COMPANY a reasonable opportunity to operationally and otherwise conclude activities related to the termination.

*Printed Name of Authorized Person Submitting Enrollment	*Printed Title of Authorized Person Submitting Enrollment
*Signature of Authorized Person Submitting Enrollment	*Submission Date

Completed forms can be submitted as follows:

Email: **HFEFTERA@Healthfirst.org**
Fax: **1-646-313-4635**
Mail: Provider Operations and Reimbursement
P.O. Box 5168, New York, NY 10274-5168

Please direct all questions to:
Telephone Number: **1-888-801-1660**