HEALTHFIRST (80141)
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
- Healthfirst EFT Authorization Form
  - **NOTE:** Providers must enroll for EFT in order to receive ERAs.

WHERE SHOULD I SEND THE FORM(S)?

- **Emdeon EnrollNow:** Once completed online, click Submit.
  - **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 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 TURN AROUND 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, ERA's can take anywhere from 14 to 45 days to begin coming through.

HOW CAN 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 Support 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 INFORMATION OF THE PAYER YOU ARE ENROLLING FOR ERAS FROM:

HEALTHFIRST - PAYER ID 80141

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: Select One

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

SUBMISSION INFORMATION:

Reason for Submission: New ERA Enrollment

Authorized Signature:

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

EFT Authorization Form

Rev. 05/10/2013

Type of Transaction (please choose)
☐ Add EFT ☐ Change EFT ☐ Terminate EFT

Physician Group Notes:
- You need only fill out one EFT Authorization form per Tax ID as long as all the providers in the group have the same bank account.
- Please attach a list of the provider IDs, at the payee entity level, for whom you wish the Authorization to apply

Provider/Physician Name (please print)

Healthfirst Provider ID Number **National Provider Identifier (NPI)** **Federal Employer Identification Number**

Provider Type (please choose one)
☐ Ancillary ☐ Hospital ☐ Physician ☐ Physician Group

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

Account Type ☐ Checking

Account Name _____

Depository/Bank Name (please print) **Address** (please print)

City **State** **Zip** **Phone**

Please include either a copy of a voided check or a letter from the bank.

Routing Number **Account Number**

Please fill out the Emdeon ERA Provider Set Up Form for ERA participation. A software clearinghouse is required.

☐ Emdeon I-UB92 UB04 ☐ Emdeon P-HCFA 1500 Other: Name _____

This authority is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination. Provider agrees that all EFT transactions will be conducted in accordance with company's policies and procedures (and may be changed from time to time) and may be suspended or discontinued at any time.

Name (please print) Title

Signature Date

Please provide the name of a contact person that can verify and provide any changes in the above listed data.

Contact Name (please print) Title Phone Number Email Address

Address City State Zip

Please directall questions to:
Phone 1-888-801-1660

Completed forms can be submitted as follows:
Mail: Provider Operations and Reimbursement
P.O. Box 5168, New York, NY 10274-5168

E-Mail: HFPROVSRVS@Healthfirst.org or fax 1-646-313-4635
www.healthfirst.org