

WHICH FORM(S) SHOULD I DO?

- **Health Net Electronic Remittance Advice (ERA) Authorization Agreement**

WHERE SHOULD I SEND THE FORM(S)?

- **Health Net Electronic Remittance Advice (ERA) Authorization Agreement**
 - Once completed, save and email to aggsetup@abilitynetwork.com or fax to (888) 999-8670.

WHAT IS THE TURN AROUND TIME?

- Please allow 3 weeks for the registration process to be completed. If after 4 weeks you do not start receiving ERAs, please contact Health Net's EDI team at (800) 977-3568.

HOW CAN I CHECK THE STATUS OF MY ERA ENROLLMENT?

- To check the status of the **Health Net Electronic Remittance Advice (ERA) Authorization Agreement**, please call Health Net's EDI team at (800) 977-3568.
- Upon registration completion, paper remits will be generated along with ERA for the first 30 days, after which paper remits will CEASE while ERA transmissions continue. For questions, contact payer at (800) 977-3568.

Health Net of California Electronic Remittance Advice (ERA) Authorization Agreement

OA

Provider Information

Provider Name _____
 Provider Address Street _____
 City _____ State _____ Zip _____

Provider Identifiers Information

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

Provider Contact Information

Provider Contact Name _____ Telephone Number _____
 Email Address _____ Fax Number _____

Provider Agent Information

Provider Agent Name _____
 Telephone Number _____ Email Address _____

Electronic Remittance Advice Information

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

Provider Tax Identification Number (EIN) _____ National Provider Identification Number (NPI) _____

Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name _____
 Telephone Number _____ Email Address _____

Electronic Remittance Advice Vendor Information

Vendor Name _____
 Telephone Number _____ Email Address _____

Submission Information

Reason for Submission: New Enrollment Change Enrollment Cancel Enrollment

Authorized Signature:

Printed Signature of Person Submitting Enrollment _____

Submission Date _____ Requested ERA Effective Date _____

This authorization is to remain in effect until written notice in the form of an ERA Authorization Agreement form marked as a cancellation or change form is submitted to Health Net. Any changes to the providers agent, clearinghouse or vendor must be submitted on an ERA Authorization Agreement form as a change. The termination or change shall be effective 20 days subsequent to Health Net's receipt of the updated form.