HEALTH NEW ENGLAND (04286)
ERA ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- Optum360 ERA Enrollment Form
- Availity Enrollment Form
- Health New England Online Enrollment
- 835 Enrollment Request

WHERE SHOULD I SEND THE FORM(S)?

- Email the Optum360 and Availity ERA form to enrollments@optum.com or fax it to (877) 630-2064.
- Complete the HNE online enrollment here: https://www.hnedirect.com/eft/EFTPage1.aspx
- Email the 835 Enrollment Request to enrollmentadmin@officeally.com or fax it to (360) 314-2184.

WHAT IS THE TURNAROUND TIME?

- The enrollment process can take approximately 30-40 business days.

Optum360 Electronic Remittance Advice Enrollment

Updated: 3/26/2018

Payer Name: Health New England (P)	Payer ID: 04286

Overview

Complete all forms as instructed below and return them via e-mail or fax for the additional processing necessary to set up your account for electronic remittance advice (ERA). We will attach your agreements to your account in our system for tracking purposes.

Estimated approval timeframe: 15-35 Business Days

Enrollment Agreement Instructions

To enroll for ERAs with Health New England (P):

1. Complete the attached Optum360 Electronic Remittance Advice Enrollment form.
2. Complete the attached payer enrollment form, which includes instructions to assist with your enrollment.

   Optum360 partners with Availity who goes through Change Healthcare / Capario to this payer for ERAs. Please follow the attached Change Healthcare instructions for enrollment with this payer. Be sure to return the Availity page that acknowledges that you have completed this enrollment.

3. Return all completed forms, along with your Optum360 Electronic Remittance Advice Enrollment form, to Optum360 via e-mail (preferred) or fax:

   Important: Include your 8-digit ENS/Optum360 user ID on all correspondence.

E-mail (preferred)	**Fax**
E-mail the completed forms to enrollments@optum.com: **1.** Click the **Submit** button at the bottom of the form. **2.** In the Send Email dialog box, select **Default email application** and click **Continue**. A new e-mail message will display with the Optum360 Electronic Remittance Advice Enrollment form attached to it. **3.** Attach the payer enrollment form to the e-mail and send the e-mail.	(877) 630-2064

Who do I contact if I have questions?

Contact the Optum360 Enrollment Department at (866) 367-9778, option 1.

Optum360
Electronic Remittance Advice Enrollment

Rev. 08.19.2016.1

Optum360 User ID: GATE0068 (Office Ally)			
PAYER INFORMATION			
Payer Name: Health New England (P)			Payer ID: 04286
RECEIVER INFORMATION			
Your ERA files will be received by the following clearinghouse:			
Receiver Name: Electronic Network Systems, Inc.			Availity Customer ID: 24932/enscommercial
Contact Name: Enrollments Department			
Telephone Number: (866) 367-9778	Ext: opt. #1	E-mail Address: enrollments@optum.com	
PROVIDER INFORMATION			**PROVIDER IDENTIFIERS INFORMATION**
Provider Name:			Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):
Street:			
City:	State/Province:	ZIP Code/Postal Code:	National Provider Identifier (NPI):
PROVIDER CONTACT INFORMATION			
Provider Contact Name:			
Telephone Number:		E-mail Address:	
ELECTRONIC REMITTANCE ADVICE INFORMATION			
Preference for Aggregation of Remittance Data	☐ Provider Tax Identification Number (TIN):		
	☐ National Provider Identifier (NPI):		
			Date:
SUBMISSION INFORMATION			
Reason for Submission:	☒ New Enrollment	☐ Change Enrollment	☐ Cancel Enrollment
Authorized Signature:			
Important: By typing or signing a name in this field, you acknowledge and agree that you have been authorized by the provider or its agent to initiate, modify, or terminate an enrollment. You further acknowledge and agree that you have the legal authority to perform such action on behalf of your organization.			
Printed Name of Person Submitting Enrollment:			Submission Date:
SEND THE FORM VIA:	**E-mail:** enrollments@optum.com	Submit	**Fax:** (877) 630-2064
Optum360 Internal use only: Update ERA in ERA Mgr.		**Availity Internal use only:**	

AVAILITY ENROLLMENT FORM

PAYER ID: 04286

PAYER NAME: HEALTH NEW ENGLAND

Required: Submission of this form is required for enrollment

Enter Provider Information (print or type)		
Provider Organization Name		
Provider Tax ID	Provider/Group NPI	
Availity Customer ID (Required) 24932/enscommercial	Provider Legacy ID (if available)	
Provider Billing Address		
City	State	Zip
Authorized Name	Phone	
Email Address		
Choose which transaction you are enrolling (Claims, Remits, or Both): Remits		

Questions: Please contact aacenrollment@availity.com

Internal Use Only: 835 setup CAPARIO

CHANGE HEALTHCARE

HEALTH NEW ENGLAND

PAYER 04286

https://www.hnedirect.com/eft/EFTPage1.aspx

Section A-ENROLLMENT SELECTION

Enrollment Type (Select One): Change to Enrollment

EFT/ERA Option (Select One): ERA Only

Practice Type (Select One): Individual Provider

Provider/Group/Facility Information

Provider/Group/Facility Name *

Provider Tax ID *

Provider NPI *

Provider Contact Name *

Provider Contact Phone *

Provider Contact Email *

Billing Address *

City *

State: AL

Zip *

* Required Fields

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Section B-PROVIDER/VENDOR/CLEARINGHOUSE/BILLING AGENT

PLEASE SELECT WHO WILL RECEIVE THE 835 ERA ELECTRONICALLY FROM HEALTH NEW ENGLAND INC.

○ Provider
◉ Vendor/ClearingHouse/BillingAgent

HEREBY CERTIFIES TO HEALTH NEW ENGLAND, INC. THE FOLLOWING WITH RESPECT TO THE 835 ELECTRONIC REMITTANCE ADVICE:

- Provider will coordinate receipt of remittance test file(s) from the designated clearinghouse/vendor if a vendor is named.
- Provider acknowledges that it will complete the test file(s) and use the 835 ERA data for posting to their accounting systems.
- Provider will notify their EDI Vendor of their intention to begin ERA testing.
- Provider agrees that upon approval of this Certification and the initiation of routine ERA processing, Provider will no longer receive a hard copy EOR (Explanation of Remittance) after thirty (30) days from production. AR-SA.
- Provider, or an authorized representative of Provider, will notify Health New England, Inc. in writing of any changes or corrections required in the ERA process.

Providers who chose to receive 835 transactions directly from HNE may elect to return a 999 Acknowledgement file. HNE does not require this but if you do opt in, you must always transmit the acknowledgement file.

☐ Please check here if you will be sending an acknowledgement file.

Vendor Name * Emdeon

Vendor Tax ID * 133052274

Vendor Contact Phone * (866) 924-4634

☑ BY CHECKING HERE, PROVIDER AUTHORIZES HEALTH NEW ENGLAND, INC. TO TRANSMIT PROVIDER'S 835 FILES TO VENDOR *

Provider/Representative Name *

Vendor Name(Appointed) *

TO ACT AS THE AUTHORIZED AGENT FOR THE PURPOSE OF RETRIEVING THE 835 ERA ELECTRONICALLY FROM HEALTH NEW ENGLAND, INC.

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Section E-PROVIDER AUTHORIZATION

The undersigned Provider hereby authorizes and requests Health New England, Inc. (HNE) to effect payment for all amounts owed to the Provider by HNE as such amounts become payable. Payment shall be made by initiating entries to the Provider's account in the bank or financial institution indicated above. The Provider authorizes and requests said bank or financial institution to credit the same to such account. This authorization is active as of two weeks after HNE receives the request and shall remain in effect until terminated. The Provider may terminate this authorization without cause by giving 15 days prior written notice to HNE. HNE may terminate this authorization without cause at any time. I agree that if unearned or erroneous payment is credited to my account by HNE, I will immediately repay HNE the full amount of such unearned or erroneous pay. I also agree to allow an automatic reversal of any deposits made in error.

If you are a provider that is not participating with Health New England's Medicare Advantage product, CMS has established guidelines outlining how Health New England must process "Non-Contract Provider Appeals for Medicare Advantage." To understand the process and the provider's rights and responsibilities, please go to: http://www.healthnewengland.com/hne_providers/index-oop.html.

Name of Authorized Representative*

Date Completed

Email Address*

Verify Email Address*

Generate New Image

Type the code from the image

Submit Form

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* Required Fields

835 ENROLLMENT REQUEST

Email this form to enrollmentadmin@officeally.com or Fax to (360) 314-2184. Once your form is received and processed Office Ally will e-mail or call you. If you do not receive a confirmation e-mail/call from us within 2-3 days of faxing this form to us, please fax it again. Please make sure to print legibly and to complete this form in its entirety. You risk delaying enrollment if the application is unreadable or incomplete. All fields in **bold** are **required**.

PROVIDER INFORMATION

Provider Name:

Provider Address: **City:** **State:** **Zip:**

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number
Employer Identification Number (EIN):

National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION

Contact Name: **Telephone Number/Extension:**

Email Address: Fax Number:

ELECTRONIC REMITTANCE ADVICE INFORMATION (CHECK ONLY ONE)

Preference for Aggregation of Remittance Data: (i.e. Account Number Linkage to Provider Identifier). Note: Provider Preference for grouping (bulking) claim payment advice. Must match preference for EFT payment (i.e. Billing Provider). Choose and fill in only **one**.

☐ Provider Federal Tax Identification Number (TIN):

☐ National Provider Identifier (NPI):

SUBMISSION INFORMATION

Reason for Submission: New ERA Enrollment

Authorized Signature:

Note: Electronic Signature (Typed Name) of Person Submitting ERA Enrollment.

Submit by Email

Clear Form

NOTE: If you have received ERA's from this payer through another clearinghouse, you may be prompted via email from your previous clearinghouse to confirm the change. If you do not confirm the change, enrollment will be delayed.