HEALTHFIRST (80141)
ERA ENROLLMENT INSTRUCTIONS

WHICH FORMS SHOULD I COMPLETE?

- **Change Healthcare 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)?

- **Change Healthcare Enrollment Services:**
    - Send completed form to:
        - Email: emdeon.ERA@officeally.com

- **Healthfirst EFT Authorization Form:**
    - Once completed, mail/fax/email form to:
        - Provider Operations and Reimbursement
          P.O. Box 5168
          New York, NY 10274-5168

        - Fax: 1-646-313-4635
        - Email: HFEFTERA@Healthfirst.org

WHAT IS THE TURNAROUND TIME?

- Once Office Ally receives your Change Healthcare ERA Enrollment Form, we will process the request within 24-48 hours.
- EFT/ERA Requests may take as many as up to 30 days to process.

HOW DO I CHECK STATUS?

- To check the status of the ERA Enrollment Form, please email Support@officeally.com or call (360) 975-7000 option 1.

Office Ally

CHANGE HEALTHCARE ERA ENROLLMENT FORM

Email this form to Emdeon.ERA@officeally.com. The Email Subject should read: Emdeon ERA Enrollment. Please print legibly and complete the 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

Please note that if you are enrolling multiple NPIs, they can be listed on the last page of the enrollment packet.

Provider Federal Tax Identification Number

Employer Identification Number (EIN): **National Provider Identifier (NPI):**

PROVIDER CONTACT INFORMATION

Contact Name: **Phone 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 only one**.

- ☐ Provider Federal Tax Identification Number (TIN):
- ☐ National Provider Identifier (NPI):

SUBMISSION INFORMATION

Reason for Submission:

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**