INDIANA PROHEALTH NETWORK (35161) ERA ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- **Emdeon ERA Enrollment Form**
- **Community ProHealth CORE ERA Enrollment Form**

WHERE SHOULD I SEND THE FORM(S)?

- Email the Emdeon ERA Enrollment Form to Support@officeally.com
- Email the Community ProHealth CORE ERA Enrollment Form to mdwod@ecommunity.com; OR fax to (317) 355-6084 Attn: Michele Dowd

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 the individual payer. Generally, EAs can take anywhere from 14 to 45 business days to begin coming through.

HOW DO I CHECK STATUS?

- To check the status of your **Emdeon ERA Enrollment 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.
- To check status on the **CORE ERA Enrollment Form**, email or call mdowd@ecommunity.com or (317) 621-7580.

CHANGE HEALTHCARE (FORMERLY EMDEON) ERA ENROLLMENT FORM

Email this form to Support@officeally.com. The Email Subject should read: Emdeon ERA Enrollment. 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:

Authorized Signature:

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

Community ProHealth
CORE ERA Enrollment Form

Provider Information

Provider Name
Provider Address
Street
City | State | Zip Code

Provider Identifiers Information

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

Other Identifiers (optional)
Assigning Authority (o)
Trading Partner ID (o)

Provider Contact Information

Provider Contact Name
Telephone Number
Email Address (if provider has email address)
Fax Number (o)

Preference for Aggregation of Remittance Data (Account Number Linkage to Provider Identifier)
(Must match EFT Preference)
Provider Tax Identification Number (TIN)
National Provider Identification Number (NPI)
Method of Retrieval (o) Clearinghouse

Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name
Telephone Number
Email Address (o)

Reason for Submission
- ☐ New Enrollment
- ☐ Change Enrollment
- ☐ Cancel Enrollment

Authorized Signature

Electronic Signature of Person Submitting Enrollment (o)
Printed Title of Person Submitting Enrollment (o)
Submission Date | Requested ERA Effective Date

Return completed forms to: Michele Dowd fax (317.355.6084)
Phone: 317.621.7580 email: mdowd@ecommunity.com