INSTAMED ERA ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- Instamed Network Funding Agreement

WHERE SHOULD I SEND THE FORM(S)?

- Fax form to: (877) 755-3392; or
- Mail form to:

  U.S. Bank Payment Accelerator
  c/o Instamed
  P.O. Box 58790
  Philadelphia, PA 19102

HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is 21 business days.

HOW DO I CHECK STATUS?

- If you have any questions or want to check on status, call Instamed at (877) 855-7160.

INSTAMED NETWORK FUNDING AGREEMENT
(Payer Payments)

This **NETWORK FUNDING AGREEMENT** (the "Agreement") shall become effective upon execution by the undersigned (hereinafter, "Customer"). The services that Customer is enrolling for pursuant to this Agreement shall be subject to the terms and conditions contained herein. Customer acknowledges that it has reviewed, and hereby agrees, by its signature below, to be bound by this Agreement.

NOTE: By registering for Payer Payments, you will receive payments from the payers listed at the following URL (http://info.instamed.com/payer-payments-payer-list) by electronic funds transfer (EFT) and claims information by electronic remittance advice (ERA). After you register for Payer Payments, you will no longer receive a paper check or paper explanation of payment (EOP) from the payers listed at the URL set forth in the prior sentence, which may be updated from time to time to add or remove payers. To opt out of Payer Payments from one or more of the available payers, please contact InstaMed at (877) 855-7160 or connect@instamed.com.

Please complete the form below, sign and send to InstaMed: (*For security purposes, please do not return this form via email.*)

- **Fax: (877) 755-3392**
  or
- **Mail: P.O. Box 58790 Philadelphia, PA 19102**

If you have any questions, please contact InstaMed at (877) 855-7160.

SECTION ONE – GENERAL INFORMATION

Provider Information (*all information is required unless otherwise noted*)

Tax ID	**Practice Administrator Contact Information**
Provider Name (*an individual*)	Name
Practice Name (*a business entity*)	Phone
Address	Email
City State Zip	Fax

SECTION TWO – NPI

NPIs

Please give your Billing Provider NPI(s) for the Provider Name above and, if populated, Practice Name. If your Practice uses Service Provider NPI(s) for claims billing, please list them also. If your Practice does not use Service Provider NPI(s) for claims billing, you do not need to list them. In order to avoid misdirected payments, only list NPI(s) that should have ALL of their remittances and payments routed to you. Do not include NPI(s) that also do business under other healthcare providers.

Billing Provider NPI (*Practice NPI*): _____ Billing Provider NPI (*Practice NPI*): _____

Service Provider NPI: _____ Service Provider NPI: _____

SECTION THREE – REMITTANCE DELIVERY

You will automatically receive Electronic Remittance Advice (ERA) through the U.S. Bank Payment Accelerator Portal. Please indicate below if you want to receive ERA via Secure File Transfer Protocol (SFTP) and/or your clearinghouse in addition.

- ☒ Receive ERA via U.S. Bank Payment Accelerator Portal
- ☐ Receive ERA via SFTP (*Optional*)
- ☒ Receive ERA via Clearinghouse (*Optional*)
  Clearinghouse Name: Office Ally

For a list of supported clearinghouses for ERA, visit: www.instamed.com/eraclearinghouses.

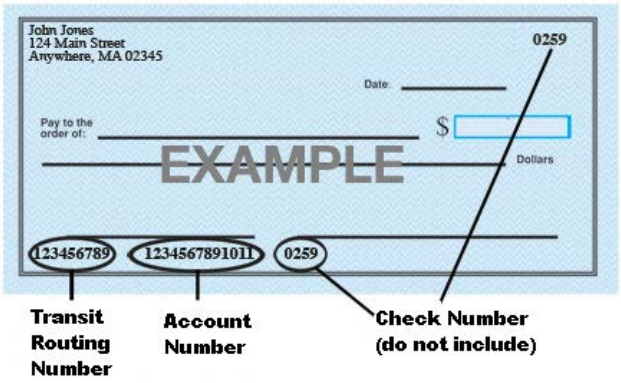
SECTION FOUR – ELECTRONIC FUNDS TRANSFER

Please complete the form below and attach a voided check or photocopy of a voided check. One form is required per bank account.

Bank Account Information

Tax ID (*same as page 1*)	Bank Street Address
Bank Name	City State Zip
Transit Routing Number (TRN) (*see graphic below*)	Account Number (*see graphic below*)

ATTACH VOIDED CHECK HERE OR ON SEPARATE PAGE OR ATTACH A PHOTOCOPY OR BANK LETTER ON A SEPARATE PAGE



SECTION FIVE – AUTHORIZATION

The undersigned authorizes U.S. Bank and/or its healthcare network affiliate InstaMed Communications, LLC D.B.A InstaMed to make electronic payments and other entries to the bank account at the depository financial institution (depository) named above for services performed under the Agreement between the organization identified above and InstaMed and its affiliates. Such entries shall be made through the regional automated clearinghouse (ACH) associations, subject to any applicable Rules promulgated by such associations. This authorization is to remain in full force and effect until InstaMed has received written notice of its termination, allowing reasonable opportunity to act on it, which shall in no event be greater than thirty (30) days after its receipt. Revocation will not apply to transactions initiated before the effective date of such revocation. InstaMed may cease providing any or all of these services upon notice to Customer. The undersigned certifies that the above information is true and accurate in all respects and that the undersigned has the authority to initiate the actions requested herein and will promptly notify InstaMed of any changes to the information on this form in writing. As mandated by the Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule, Requirement 4.1, Customer must proactively contact its financial institutions in order to access the EFT trace number and other minimum data elements necessary to reassociate the EFT with the ERA.

Authorized Signature

Name of Customer: _____ Date: _____

Signature: _____

Print Name: _____

Print Title: _____

Internal Use Only: Network Build Initials: _____