KPS health plans

Electronic Remittance Advice Enrollment

Use this form to request set up for electronic remittance advice.

Submit the completed form to providersystemsadmin@ghc.org or fax your request to 206-988-2001. Once your submission is received, it will normally be processed within 10 business days. The requester will be notified when setup is complete.

Provider information

Provider Name: _____

Doing Business as Name (DBA): _____

Street: _____

City: _____ State/Province: _____ Zip Code/Postal Code: _____

Provider Identifiers Information		
Provider Identifier (Tax ID or EIN)	Tax ID:	EIN:
Provider NPI (Required when provider has an NPI)		
Electronic Remittance Advice Provider Information		
Provider Contact Name		
Telephone Number		
Email Address		
Electronic Remittance Advice Information		
Preference for Aggregation of Remittance Data; Linkage to Provider ID. Must match EFT payment. (Tax ID or NPI)	Tax ID:	EIN:
Electronic Remittance Advice Clearinghouse Information For a list of clearinghouses that transmit electronic remittance advice from KPS, see link, http://www.kpshealthplans.com/docs/kps-affiliated-clearinghouse.pdf		
Clearinghouse Name	OFFICE ALLY	
Clearinghouse Contact Name	Customer Service	
Telephone Number	360-975-7000 Option 1	
E-mail Address	Support@officeally.com	
Submission Information		
Reason for Submission	❒ New enrollment ❒ Change enrollment ❒ Cancel enrollment	
Requested ERA Effective Date		

I hereby authorize KPS Health Plans to begin sending Electronic Remittance Advice with the information supplied above.

This authority is to remain in full force and effect during my participation with KPS Health Plans. I understand thirty (30) days notice in writing, to KPS Health Plans is required if a change to clearninghouse or discontinue of this arrangement is needed.

Authorized Signature: _____

Date: _____

Printed Name: _____

Title: _____

Have you provided all of the following information?

- ❒ **Provider Name:** Complete legal name of institution, corporate entity, practice or individual provider.
- ❒ **Doing Business As Name:** The name you are doing business as. A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it.
- ❒ **Provider Address:** The number and street name where the provider organization can be found.
- ❒ **City:** City associated with the provider address field.
- ❒ **State:** Two Character Code associated with the state associated with the provider address field.
- ❒ **Provider Federal Tax ID Number or EIN:** Your Federal Identification Number.
- ❒ **National Provider Identifier (NPI):** The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard.
- ❒ **Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier):** Provider preference for grouping claim payments. Must be either TIN or NPI and must match EFT if provider is also enrolled in EFT.
- ❒ **Provider Contact Name:** Name of the contact person in the provider's office that can handles ERA issues.
- ❒ **Telephone Number:** The telephone number of the provider's contact person for handling ERA issues.
- ❒ **E-mail Address:** The email address of the provider's contact person for handling ERA issues.
- ❒ **Clearinghouse Name:** The name of the Clearinghouse you wish to use for ERA
- ❒ **Clearinghouse Contact Name:** The contact name of the person at the Clearinghouse that can answer questions regarding ERA
- ❒ **Clearinghouse Telephone Number:** The telephone number of the Clearinghouse
- ❒ **Clearinghouse E-mail Address:** The email address of the Clearinghouse contact
- ❒ **Reason for Submission:** Must select one from; New Enrollment, Change Enrollment, Cancel Enrollment.
- ❒ **Requested ERA Effective Date:** The date the provider wants to begin ERA.
- ❒ **Written Signature of Person Submitting Enrollment:** The cursive name of the person used as confirmation of authorization.
- ❒ **Submission Date:** The date the enrollment was submitted.
- ❒ **Printed title:** The printed title of the person submitting the enrollment.

For inquires call customer service toll-free at 1-877-693-2269 or e-mail: edisupport@ghc.org.
Instructions are also found on our website at kpshealthplans.com.