

MEDICAID CONNECTICUT (MCDCT) ERA ENROLLMENT FORM



Email this form to support@officeally.com or Fax it to (360) 896-2151.
The turnaround time for ERA enrollment is 7-10 business days.

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 AVRS ID:

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.