MEDICAID MASSACHUSETTES ERA/EFT (MCDMA) ERA ENROLLMENT INSTRUCTIONS

EFT enrollment must be completed along with the ERA (835) enrollment.

WHAT FORM(S) SHOULD I DO?

- Electronic Funds Transfer (EFT) Enrollment/Modification Form
- Electronic Remittance Advice Enrollment/Modification Form
    - Electronic Remittance Advice Clearinghouse Information
        - Clearinghouse Name: Office Ally
        - Clearinghouse Contact name: Customer Service
        - Telephone number (360) 975-7000 option 1
        - E-mail address: Support@officeally.com

WHERE SHOULD I SEND THE FORM(S)?

- Forms should be mailed with **Original** signatures in **BLUE** ink to:

    MassHealth Customer Service
    Attn: Provider Enrollment and Credentialing
    PO Box 9162
    Canton, MA 02021

WHAT IS THE TURNAROUND TIME FOR ERA ENROLLMENT?

- Standard processing time is 30 days.

HOW DO I CHECK STATUS?

- To check the status of your enrollment, call (800) 841-2900 option 2, 3 and then 1.

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

Electronic Funds Transfer (EFT) Enrollment/Modification Form

Complete this form to enroll in electronic funds transfer (EFT) with MassHealth or to terminate or modify an existing electronic funds agreement. Additional terms of agreement on page 2 of this form must be completed.

PROVIDER INFORMATION

Provider Legal Name	DBA Name		
Street	City	State	Zip Code

PROVIDER IDENTIFIERS INFORMATION

Provider TIN or EIN	NPI

PROVIDER CONTACT INFORMATION

Provider Contact Name	
Telephone Number	Telephone Number Extension
E-mail Address	

FEDERAL AGENCY INFORMATION

Federal Program Agency Identifier

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name			
Street	City	State	Zip Code
Financial Institution Routing Number	Type of Account at Financial Institution		
Provider's Account Number with Financial Institution			
Provider TIN	NPI		

SUBMISSION INFORMATION

Reason for Submission ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment	Included ☐ Voided Check ☐ Bank Letter
Written Signature of Person Submitting Enrollment	
Printed Name of Person Submitting Enrollment	Submission Date

If you are modifying or changing your bank account information, you must include your old bank account information on page 2 of this form or your request will be incomplete.

Please print double-sided whenever possible.

Please complete page 2 in its entirety.

If you are modifying your bank account information please provide the old bank account information directly below.

Provider Old Bank Account Number _____ Account Type ☐ Checking ☐ Savings

CERTIFICATION

I, _____ , hereby certify that the account(s) indicated on this form is under my direct control and access; therefore, I authorize the State Treasurer as fiscal agent for the Commonwealth of Massachusetts to initiate, change, or cancel credit entries to that account/s as indicated on this form. For ACH debits consistent with the International ACH Transaction (IAT) rules check one:

☐ I affirm that payments authorized hereunder are not to an account that is subject to being transferred to a foreign bank account.

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This authority is to remain in full force and effect until the Office of Comptroller (CTR) has received written notification from either me or an authorized officer of the organization of the account's termination in such time and in such a manner as to afford CTR a reasonable opportunity to act upon it.

This authorization will remain in effect until it is canceled in writing or until an updated form changing information is sent to the department you currently do business with.

Signature of authorized representative _____

- Please contact your financial institution to arrange for the delivery of the CORE (Committee on Operating Rules for Information Exchange)-required Minimum CCD+(Corporate Credit or Debit entry) data elements needed for reassociation of the payment and the Electronic Remittance Advice (ERA).
- Instructions to complete the EFT Enrollment/Modification form can be found at www.mass.gov/eohhs/docs/masshealth/aca/eft-instructions.pdf. You may also confirm the status of your EFT enrollment by contacting the MassHealth Customer Services Center at 1-800-841-2900.
- The EFT user job aid that explains how providers may match the EFT payment to the remittance advice can be found at https://massfinance.state.ma.us/VendorWeb/MassHealthProviderJA.asp.
- The EFT Enrollment/Modification form can be completed manually or electronically. Electronic submissions must be printed, signed, and mailed to the address below. The Commonwealth of Massachusetts requires a "wet" signature on all EFT enrollments, modifications, and terminations. All paper forms must be mailed to the following address.

MassHealth Customer Services Center
Attn: Provider Enrollment and Credentialing
P.O. Box 9162
Canton, MA 02021-5213

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

Electronic Remittance Advice Enrollment/Modification Form

PROVIDER INFORMATION

Provider Legal Name	DBA Name		
Street	City	State	Zip Code

PROVIDER IDENTIFIERS INFORMATION

Provider TIN or EIN	NPI

Other Identifier(s)

Assigning Authority	Trading Partner ID
Provider Type	Provider Taxonomy Code

PROVIDER CONTACT INFORMATION

Provider Contact Name	Title	
Telephone Number	Telephone Number Extension	Fax Number
E-mail Address		

PROVIDER AGENT INFORMATION

Provider Agent Name			
Street	City	State	Zip Code

Provider Agent Contact Name	Title
Telephone Number	Telephone Number Extension
E-mail Address	Fax Number

RETAIL PHARMACY INFORMATION

Pharmacy Name		
Chain Number	Parent Organization ID	Payment Center ID

NCPDP Provider ID Number	Medicaid Provider Number

ELECTRONIC REMITTANCE ADVICE INFORMATION

Provider Tax ID	Provider NPI	Method of Retrieval

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION	
Clearinghouse Name Office Ally (110083303A)	
Clearinghouse Contact Name Customer Service	
Telephone number 360-975-7000	E-mail Address Support@officeally.com

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION	
Vendor Name	
Vendor Contact Name	
Telephone Number	E-mail Address

SUBMISSION INFORMATION	
Reason for Submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment	
Written Signature of Person Submitting Enrollment	
Printed Name of Person Submitting Enrollment	
Printed Title of Person Submitting Enrollment	
Submission Date	Requested ERA Effective Date

- Instructions to complete the ERA Enrollment/Modification form can be found at www.mass.gov/eohhs/docs/masshealth/aca/era-instructions.pdf.
  You may also confirm the status of your ERA enrollment by contacting MassHealth Customer Service at 1-800-841-2900.
- The ERA Enrollment/Modification form can be completed manually or electronically via the Provider Online Service Center (POSC). All paper forms must be mailed to the following address:

MassHealth Customer Service
Attn: Provider Enrollment and Credentialing
P.O. Box 9162
Canton, MA 02021