MEDICARE MISSOURI PART B (05302)
ERA ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- **Electronic Remittance Advice (ERA) Authorization Agreement**

WHERE SHOULD I SEND THE FORM(S)?

- Email to edimedicareb@wpsic.com; OR
- Fax to (608) 223-3824; OR
- Mail to
    - Medicare MACJ5 Part B
      WPS Medicare EDI
      1717 West Broadway
      Madison, WI 53713

HOW DO I CHECK STATUS?

- Send an email to edimedicareb@wpsic.com or call (866) 518-3285 and ask if your ERAs have been linked to Office Ally's Trading Partner ID **98366**.

Electronic Remittance Advice (ERA) Authorization Agreement

This document is intended to establish Electronic Remittance Advice (ERA) enrollment. This document shall become effective when submitted by the provider. The responsibilities and obligations contained in this document will remain in effect as long as claims are submitted to WPS. Either party may terminate this arrangement by giving the other party thirty (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

DEG1: Provider Information

Provider Name:

Doing Business As Name (DBA):

Provider Address

Street: City: State/Province:

Zip Code/Postal Code: Country Code:

DEG2: Provider Identifiers Information

Provider Identifiers

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):

National Provider Identifier (NPI):

Other Identifier(s)

Assigning Authority: Trading Partner ID:
Medicare Missouri Part B (J5) 98366

Provider License Number: License Issuer:

Provider Type: Provider Taxonomy Code:

DEG3: Provider Contact Information

Provider Contact Name:

Title:

Telephone Number: Telephone Number Extension:

Email Address: Fax Number:

DEG4: Provider Agent Information

Provider Agent Name:

Agent Address

Street: City: State/Province:

Zip Code/Postal Code: Country Code:

Provider Agent Contact Name: Title:

Telephone Number: Telephone Number Extension:

Email Address: Fax Number:

DEG5: Federal Agency Information

Federal Program Agency Name:

Federal Program Agency Identifier:

Federal Agency Location Code:

DEG6: Retail Pharmacy Information

Pharmacy Name:

Chain Number:

Parent Organization ID:

Payment Center ID:

NCPDP Provider ID Number:

Medicaid Provider Number:

DEG7: Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data

Provider Tax Identification Number (TIN):

National Provider Identifier (NPI):

Method of Retrieval:
Clearinghouse

DEG8: Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name:
Office Ally, Inc.

Clearinghouse Contact Name:
Customer Service

Telephone Number:
360-975-7000 Option 1

Email Address:
support@officeally.com

DEG9: Electronic Remittance Advice Vendor Information

Vendor Name:

Vendor Contact Name:

Telephone Number:

Email Address:

DEG10: Submission Information

Reason for Submission: ◯ New Enrollment ◯ Change Enrollment ◯ Cancel Enrollment

Authorized Signature

Printed Name of Person Submitting Enrollment:

Submission Date:

Requested ERA Effective Date:

Please send the completed form via mail, email or fax to:

MEDICARE
MACJ5 National Part A,
MACJ5 Part A/B,
MACJ8 Part A/B

WPS Medicare EDI
1717 West Broadway
Madison, WI 53713

Fax:(608) 223-3824
Phone J5:(866) 518 3285
Phone J8:(866) 234-7331

Email Medicare Part A:
edimedicarea@wpsic.com

Email Medicare Part B:
edimedicareb@wpsic.com