# Electronic Remittance Advice (835) Enrollment Request

MEMORIALCARE HEALTH SYSTEM
*Excellence in Health Care*

## INSTRUCTION

Please make sure to complete this form in its entirety. **All information entered on this form should be the same information shown on your W-9 or Income Tax.** Incomplete information will result in a delay with your request. Please email the completed form to MCMF.EDISupport@memorialcare.org.

## PROVIDER INFORMATION

**Provider Name:**

**Address:**

**City:** **State:** **Zip Code:**

## PROVIDER IDENTIFIER INFORMATION

**Provider Federal Tax Identification Number**
**Employer Identification Number (EIN):**

**National Provider Identifier (NPI):**

## PROVIDER CONTACT INFORMATION

**Contact Name:**

**Phone Number:** **Email:**

## SUBMISSION INFORMATION

**Reason for Submission:** New ERA Enrollment

**Comment:**

## SIGNATURE

**Authorized Signature:**

Note: Electronic Signature (Typed Name) of Person Submitting ERA Enrollment Form.