ERA Enrollment Form
Clearinghouse: Office Ally (Payer ID IP097)

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 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: New ERA Enrollment

Authorized Signature:

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

Fax the completed form to: (415) 884-1241

Meritage Medical Network

4 Hamilton Landing, Suite 100
Novato, CA 94949

Finance Department
Please fax this form back to
Secure fax # **415-883-7127**
Attn: Adrienne Duff

ACH - Electronic Funds Transfer - Signup Form

Required Information

Please Print

Vendor/Payee Name:_____

Address 1:_____

Address 2:_____

City, State, Zip:_____

Tax ID # _____ - _____

or

Social Security No. _____ - _____ - _____

Complete for ACH - Electronic Funds Transfer

A voided check must be provided with this request.

I would like my payments deposited into the following bank account:

Bank Name: _____

Deposit Into: (check one)

Checking ☐

Savings ☐

Account No: _____

Bank Routing No: _____

Signature _____ **Date** _____

Phone Number _____

Email Address _____

Return this original form to the ***Meritage Medical Network*** in the enclosed envelope.