# MODA HEALTH (13350) ERA ENROLLMENT INSTRUCTIONS



#### WHICH FORM(S) SHOULD I DO?

- Moda Health/ODS Electronic Remittance Advice (ERA) Enrollment Form
- Moda Health/ODS Electronic Fund Transfer Enrollment Form
  - o You must complete EFT enrollment in order to activate ERA's

#### WHERE SHOULD I SEND THE FORM(S)?

Fax to: (503) 412-4068; or

Mail to:

Moda Health/ODS/ODS Community ATTN: EDI Department 601 SW Second Ave Portland, OR 97204

#### WHAT IS THE TURN AROUND TIME?

Average processing time is 5-7 business days

Phone: 360-975-7000 Fax: 360-896-2151

## Moda Health/ODS / ODS Community Health Electronic Remittance Advice (ERA) Enrollment Form

PROVIDER INFORMATION Provider Name:			
Doing Business As Name (DBA):			
Provider Address:			
Street			
City	onestellinistem		
State/Province	imotrophi:		
ZIP Code/Postal Code	<del>reconstructions</del>		
PROVIDER CONTACT INFORMATION  Provider Contact Name:			
Telephone Number:	ati institus varia araine en anticiona arango anguaga araini (anguaga araini anguaga araini anguaga araini ang		
	MANAGEM COLOR DE LA COLOR DE L		
Telephone Number extension:			
Email Address:	nstandad as anna ann an da		
ELECTRONIC REMITTANCE ADVICE INFORMATION			
Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier)			
Provider Federal Tax Identification Number (TIN):			
National Provider Identifier (NPI):			
Method of Retrieval:			
ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION			
Clearinghouse Name			
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SUBMISSION INFORMATION	
Reason for Submission:	
New Enrollment	
Change Enrollment	
Cancel Enrollment	AND THE STREET OF THE STREET O
Authorized Signature	
Written Signature	P-4
Printed Name	
Printed Title	
Submission Date	
	(ccyymmdd)

Confidential when completed. Please mail or fax form to:

Moda Health/ODS/ODS Community

ATTN: EDI Department 601 SW Second Ave Portland, OR 97204 Fax #: 503-412-4068

NOTE: Do not send completed form via email.

### Moda Health/ODS / ODS Community Health Electronic Fund Transfer Enrollment Form

PROVIDER INFORMATION Provider Name:		Antonio manda (Albania) di dispini di di
Doing Business As Name (DBA):	And the state of t	
Provider Address:		
Street	MHR.	w
City		<b>a</b>
State/Province		-
ZIP Code/Postal Code		•
PROVIDER IDENTIFIERS INFORMATION	ON	
Provider Identifier		
Provider Federal Tax Identification Number (TIN) or Employer		
Identification Number (EIN):		
• • •		•
National Provider Identifier (NPI):		•
Other Identifier(s)		
Provider Taxonomy Code:		
PROVIDER CONTACT INFORMATION		
Provider Contact Name:		annina financia annina administrativa and
Telephone Number:		
Telephone Number extension:		
Email Address:		
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FINANCIAL INSTITUTION INFORMAT Financial Institution Name:	TON		
Financial Institution Routing Number:			
Type of Account at Financial Institution:			
Provider's Account Number with Financial Institution:			
Account Number Linkage to Provider Identifier: Provider Tax Identification Number (TIN):			
National Provider Identifier (NPI):			
SUBMISSION INFORMATION			
Reason for Submission:			
New Enrollment			
Change Enrollment			
Cancel Enrollment			
Authorized Signature			
Written Signature			
Printed Name			
Printed Title			
Submission Date			
Submission Date	(ccyymmdd)		
Confidential when completed. Please mail or fax form to:  Moda Health/ODS/ODS Community			
ATTN: EDI Department			
601 SW Second Ave			
Portland, OR 97204			
Fax #: 503-412-4068			

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