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
    - 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

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 _____

State/Province _____

ZIP Code/Postal Code _____

PROVIDER CONTACT INFORMATION

Provider Contact Name: _____

Telephone Number: _____

Telephone Number extension: _____

Email Address: _____

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: Clearinghouse

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

Clearinghouse Name Office Ally

SUBMISSION INFORMATION

Reason for Submission:

New Enrollment ☐

Change Enrollment ☐

Cancel Enrollment ☐

Authorized Signature

Written Signature _____

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: _____

Doing Business As Name (DBA): _____

Provider Address:

Street _____

City _____

State/Province _____

ZIP Code/Postal Code _____

PROVIDER IDENTIFIERS INFORMATION

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: _____

Telephone Number: _____

Telephone Number extension: _____

Email Address: _____

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name: _____

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 _____
(ccyymmdd)

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