MODA HEALTH/ ODS ERA ENROLLMENT FORM

WHAT FORM SHOULD I USE?

- Moda Health/ ODS requires Providers enroll for EFT to receive ERA's
- ERA & EFT forms can be faxed or mailed. Emails are not accepted

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

  Fax#: 503-412-4068

HOW LONG DOES ERA ENROLLMENT TAKE?

- 1 Business week

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: _____

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 _____
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