MONTEFIORE CMO (13174)
ERA ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- Send an email to Support@officeally.com with the following information:
    - Email Subject: Montefiore (CMO)
        - Provider Name
        - Provider Tax ID
        - Billing Provider NPI
- **ERA Authorization Agreement**
- **EFT Authorization Agreement** (If enrolling for EFT, ERA enrollment is required)

WHERE SHOULD I SEND THE FORM(S)?

- **ERA Authorization Agreement** can be faxed to (914) 377-4794 OR mailed to:
    - Montefiore CMO
      200 Corporate Drive
      Yonkers, NY 10701
- **EFT Authorization Agreement** requires an original signature and **must** be MAILED to the address above.

NOTE: *Documents must be signed in black or blue ink only.*

WHAT IS THE TURNAROUND TIME?

- Standard processing time is 30 business days

HOW DO I CHECK STATUS?

- To check the status of your enrollment, send an email to cmoproviderrelations@montefiore.org to verify that you are linked to Post-N-Track for ERAs.

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ELECTRONIC REMITTANCE ADVICE (ERA) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

☐ New ERA Authorization
☐ Revision to Current Authorization (e.g. account or bank changes)

Since your last ERA authorization agreement submission, have you had a:
☐ Change of Ownership, and/or
☐ Change of Practice Location?
☐ Other: _____

If you checked either "Change of Ownership" or "Change of Practice Location," you must contact the CMO Provider Relations Department's main line at 914-377-4477. Before proceeding, submit a change of information letter detailing your updated service and billing information with a W9 form.

PART II: PROVIDER OR SUPPLIER INFORMATION

Provider/Supplier Legal Business Name
Chain Organization Name or Home Office Legal Business Name (if different from Chain Organization Name)
Account Holder's Street Address
Account Holder's City, State, and Zip Code
Tax Identification Number (designate SSN or EIN)
Medicare Identification Number (if issued)
National Provider Identifier (NPI)

PART III: CLEARINGHOUSE USED

Do you submit claims electronically? ☐ Yes ☐ No	**If yes, which electronic clearinghouse are you using to submit your electronic claims?** ■ Post and Track ☐ Emdeon ☐ Other: _____

PART IV: CONTACT PERSON

Contact Person's Name	Contact Person's Title
Contact Person's Telephone Number	Contact Person's E-mail Address

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PART V: AUTHORIZATION

I hereby authorize the Montefiore Care Management Organization (CMO) to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any duplicate or erroneous entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account. CMO may assign its rights and obligations under this agreement to CMO designated fee-for-service contractors. CMO may change its designated contractor at their discretion.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of Medicare payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/ Supplier, the said Provider or Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the CMO has received written notification from me of its termination in such time and such manner as to afford CMO and the Financial Institution a reasonable opportunity to act on it. CMO will continue to send the direct deposit to the Financial Institution indicated above until notified by me that I wish to change the Financial Institution receiving the direct deposit. If my Financial Institution information changes, I agree to submit to CMO an updated EFT Authorization Agreement.

SIGNATURE LINE

Authorized/Delegated Official Name (Print)	Authorized/Delegated Official Telephone Number
Authorized/Delegated Official Title	Authorized/Delegated Official E-mail Address
Authorized/Delegated Official Signature *(Note: Must be original signature in blue or black ink.)*	Date

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MONTEFIORE CARE MANAGEMENT

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

Per 42 CFR 424.510(e)(1), providers and suppliers are required to receive electronic funds transfer (EFT) at the time of enrollment, revalidation, change of Medicare contractors or submission of an enrollment change request; and (2) submit the CMO-588 form to receive Medicare payment via electronic funds transfer.

The information collected will be entered into system No. 09-70-0501, titled "Carrier Medicare Claims Records," and No. 09-70-0503, titled "Intermediary Medicare Claims Records" published in the Federal Register Privacy Act Issuances, 1991 Comp. Vol. 1, pages 419 and 424, or as updated and republished. Disclosures of information from this system can be found in this notice. You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.

INSTRUCTIONS FOR COMPLETING THE EFA AUTHORIZATION AGREEMENT

All EFT requests are subject to a 30-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made.

PART I: REASON FOR SUBMISSION

Indicate your reason for completing this form by checking the appropriate box: New EFT authorization or change to your account information. If you are authorizing EFT payments to the home office of a chain organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the home office of the chain organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

PART II: PROVIDER OR SUPPLIER INFORMATION

Line 1: Enter the provider's/supplier's legal business name or the name of the physician or individual practitioner, as reported to the Internal Revenue Service (IRS). The account to which EFT payments are made must exclusively bear the name of the physician or individual practitioner, or the legal business name of the person or entity enrolled with Medicare.
Line 2: Enter the chain organization's name or the home office legal business name if different from the chain organization name.
Line 3: Enter the account holder's street address.
Line 4: Enter the account holder's city, state, and zip code.
Line 5: Enter the tax identification number as reported to the IRS. If the business is a corporation, provide the Federal employer identification number, otherwise provide your Social Security Number.
Line 6: If issued, enter the Medicare identification number assigned by a Medicare fee-for-service contractor. If you are not enrolled in Medicare, leave this field blank.
Line 7: Enter the ten digit NPI number. The NPI number is required to process this form.

PART III: CLEARINGHOUSE USED

CMO uses the Post and Track and Emdeon clearinghouses for electronic claims submission. Please check the one you use.

PART IV: CONTACT PERSON

Enter the name and title of a contact person who can answer questions about the information submitted on this CMO-588 form. **Line 14**: Enter the contact person's telephone number. Enter the contact person's e-mail address.

PART V: AUTHORIZATION

By your signature on this form you are certifying that the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider or Supplier. The Provider or Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable Medicare regulations and instructions. All arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable Medicare regulations and instructions with the effective date of the EFT authorization. you must notify CMO regarding any changes in the account in sufficient time to allow the contractor and the Financial Institution to act on the changes.

The ERA authorization form must be signed and dated by the same Authorized Representative or a Delegated Official named on the CMO-855 Medicare enrollment application which the Medicare contractor has on file. Include a telephone number where the Authorized Representative or Delegated Official can be contacted.

Mail this form with the original signature in black or blue ink (no facsimile signatures can be accepted) to the Montefiore CMO, 200 Corporate Drive Yonkers, NY 10701. An ERA authorization form must be submitted for each provider to whom you submit claims for payment.

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MONTEFIORE CARE MANAGEMENT

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

☐ New EFT Authorization
☐ Revision to Current Authorization (e.g. account or bank changes)
☐ Change of Ownership, and/or
☐ Change of Practice Location?
☐ Other: _____
☐ Check here if EFT payment is being made to the Home Office Chain

If you checked either "Change of Ownership" or "Change of Practice Location," you must contact the CMO Provider Relations Department's main line at 914-377-4477. Before proceeding, submit a change of information letter detailing your updated service and billing information with a W9 form.

PART II: PROVIDER OR SUPPLIER INFORMATION

Provider/Supplier Legal Business Name
Chain Organization Name or Home Office Legal Business Name (if different from Chain Organization Name)
Account Holder's Street Address
Account Holder's City, State, and Zip Code
Tax Identification Number (designate SSN or EIN)
Medicare Identification Number (if issued)
National Provider Identifier (NPI)

PART III: CLEARINGHOUSE USED

Do you submit claims electronically? ☐ Yes ☐ No	**If yes, which electronic clearinghouse are you using to submit your electronic claims?** ☑ Post and Track ☐ Emdeon ☐ Other: _____

PART IV: FINANCIAL INSTITUTION INFORMATION

Financial Institution Name
Financial Institution Street Address
Financial Institution City, State, and Zip Code
Financial Institution Telephone Number
Financial Institution Contact Person
Financial Institution Routing Transit Number (nine digit)
Type of Account (check one): ☐ Checking Account ☐ Savings Account
Deposit Account Number

Please include a confirmation of account information on bank letterhead or a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number, and account type. If submitting bank letterhead, the bank officer's name and signature is also required. This information will be used to verify your account number.

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MONTEFIORE CARE MANAGEMENT

PART V: CONTACT PERSON

Contact Person's Name	Contact Person's Title
Contact Person's Telephone Number	Contact Person's E-mail Address

PART VI: AUTHORIZATION

I hereby authorize the Montefiore Care Management Organization (CMO) to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any duplicate or erroneous entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account. CMO may assign its rights and obligations under this agreement to CMO designated fee-for-service contractors. CMO may change its designated contractor at their discretion.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of Medicare payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/ Supplier, the said Provider or Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the CMO has received written notification from me of its termination in such time and such manner as to afford CMO and the Financial Institution a reasonable opportunity to act on it. CMO will continue to send the direct deposit to the Financial Institution indicated above until notified by me that I wish to change the Financial Institution receiving the direct deposit. If my Financial Institution information changes, I agree to submit to CMO an updated EFT Authorization Agreement.

SIGNATURE LINE

Authorized/Delegated Official Name (Print)	Authorized/Delegated Official Telephone Number
Authorized/Delegated Official Title	Authorized/Delegated Official E-mail Address
Authorized/Delegated Official Signature *(Note: Must be original signature in blue or black ink.)*	Date

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The information collected will be entered into system No. 09-70-0501, titled "Carrier Medicare Claims Records," and No. 09-70-0503, titled "Intermediary Medicare Claims Records" published in the Federal Register Privacy Act Issuances, 1991 Comp. Vol. 1, pages 419 and 424, or as updated and republished. Disclosures of information from this system can be found in this notice. You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.

INSTRUCTIONS FOR COMPLETING THE EFT AUTHORIZATION AGREEMENT

All EFT requests are subject to a 30-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made.

PART I: REASON FOR SUBMISSION

Indicate your reason for completing this form by checking the appropriate box: New EFT authorization or change to your account information. If you are authorizing EFT payments to the home office of a chain organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the home office of the chain organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

PART II: PROVIDER OR SUPPLIER INFORMATION

Line 1: Enter the provider's/supplier's legal business name or the name of the physician or individual practitioner, as reported to the Internal Revenue Service (IRS). The account to which EFT payments are made must exclusively bear the name of the physician or individual practitioner, or the legal business name of the person or entity enrolled with Medicare.
Line 2: Enter the chain organization's name or the home office legal business name if different from the chain organization name.
Line 3: Enter the account holder's street address.
Line 4: Enter the account holder's city, state, and zip code.
Line 5: Enter the tax identification number as reported to the IRS. If the business is a corporation, provide the Federal employer identification number, otherwise provide your Social Security Number.
Line 6: If issued, enter the Medicare identification number assigned by a Medicare fee-for-service contractor. If you are not enrolled in Medicare, leave this field blank.
Line 7: Enter the ten digit NPI number. The NPI number is required to process this form.

PART III: CLEARINGHOUSE USED

CMO uses the Post and Track and Emdeon clearinghouses for electronic claims submission. Please check the one you use.

PART IV: FINANCIAL INSTITUTION INFORMATION

Line 8: Enter your Financial Institution's name (this is the name of the bank or qualifying depository that will receive the funds). Note: The account name to which EFT payments will be paid is to the name submitted on Part II of this form.
Line 9: Enter the street address where your financial institution is located.
Line 10: Enter the city, state, and zip code where your financial institution is located.
Line 11: Enter the telephone number of your financial institution.
Line 12: Enter the name of your account representative or contact person.
Line 13: Enter the routing number for your financial institution.
Line 14: Enter the account type.
Line 15: Enter the deposit account number.

If you do not submit this information, your EFT authorization agreement will be returned without further processing.

PART V: CONTACT PERSON

Enter the name and title of a contact person who can answer questions about the information submitted on this CMO-588 form. **Line 14**: Enter the contact person's telephone number. Enter the contact person's e-mail address.

PART VI: AUTHORIZATION

By your signature on this form you are certifying that the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider or Supplier. The Provider or Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable Medicare regulations and instructions. All arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable Medicare regulations and instructions with the effective date of the EFT authorization. you must notify CMO regarding any changes in the account in sufficient time to allow the contractor and the Financial Institution to act on the changes.

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