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MOUNTAIN HEALTH CO-OP (MHC01) ERA-ENROLLMENT INSTRUCTIONS

WHICH FORMS SHOULD I COMPLETE?

This payer requires EFT to receive the ERA files.

- Complete the 835 ERA Enrollment Form & Authorization Agreement for Electronic Transfer of Funds
  - Requires either a voided check or a bank letter

WHERE SHOULD I SEND THE FORM(S)?

- Email completed forms to **both** **WHPS.ASOMHCproviderservices.ext@wipro.com** **and** **Optum.ERA@officeally.com**
  - Subject: ERA Enrollment_Mountain Health Co-Op MHC01_(insert NPI)
  - Email Body:
    - Please process the attached ERA/EFT Enrollment form to enroll Mountain Health Co-Op

WHAT IS THE TURNAROUND TIME?

- Standard Processing Time can take up to 30 Business Days.

HOW DO I CHECK STATUS?

- If after 30 business days you have not begun receiving electronic remittance files, please email back from the auto-generated response with your Case Number to check on the status of the ERA Enrollment request.

835 ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT FORM

Please complete the following information:

____Activate Enrollment: Date: ____/____/______ **____Terminate Enrollment: Date: ____/____/______**

Provider Name: ____

Provider Address: _______________________________________ **City:** __________________ ____________

State: _____ **Zip Code:** _________-________ **Provider Contact:** ____________________________________

Provider Phone Number: (______)-________-________

Provider Tax Identification Number (TIN): ___________________________________

Provider National Provider Identifier (NPI):___________________________________

Clearinghouse Name: Change Healthcare

Vendor Name: ____

This authority is to remain in full force and effect until HealthPlan Services has received written notification from me on its termination in such time and such manner as to afford HealthPlan Services a reasonable time to act on notification.

Authorized Signature: ____ **Date: ____/____/______**

Electronic Remittance Advise (ERA) – New Enrollment

AUTHORIZATION AGREEMENT FOR ELECTRONIC TRANSFER OF FUNDS

I Hereby authorize and request Mountain Health Co-Op, as claims administrator to initiate credit entries as designated owing to me for services rendered to the account indicated below in the depository financial institution named below, hereafter called DEPOSITORY. This request becomes EFFECTIVE WITHIN TWO WEEKS OF RECEIPT OF THIS DOCUMENT. Thereafter, credits for services rendered will be direct deposit. It is very important that you verify account and ABA numbers with your Depository Institution. Incorrect format can lead to rejection or delay of the funds.

( ) New Authorization ( ) Termination ( ) Replace Current

Savings or Checking ______________________ Depository Institution ______________________ ABA/Transit Number* ______________________ Account Number

Bank Contact Information ______________________________ Name ______________________ Telephone Number

Provider Email ____

This authority is to remain in full force and effect until WHPS has received written notification from me on its termination in such time and in such manner as to afford WHPS a reasonable time to act on it.

TAX IDENTIFICATION NUMBER ______________________ DATE: ______________________

PROVIDER NAME ______________________ (Please Print) SIGNATURE ______________________

NOTE: Please attach either a voided blank check for Checking <u>or</u> savings account deposit slip for Savings account changes <u>or</u> complete banking information on the bank's letterhead is required to complete the request.
Email completed documents to: WHPS.ASOMHCproviderservices.ext@wipro.com

* Bank's routing number taken from the MICR line of the recipient's check.
The first digit should be 0, 1, 2, or 3. A routing number starting with 4-9 is usually not valid.

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