



NETWORK HEALTH (TUFTS) (04332) PRE-ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- **Optum 835 Enrollment Request**
- **Change Healthcare Remittance Form**
- **Electronic Data Interchange (EDI) Intake Form**

WHERE SHOULD I SEND THE FORM(S)?

- Email all forms to Support@officeally.com

WHAT IS THE TURNAROUND TIME?

- Standard processing time is 14-20 business days

HOW DO I CHECK STATUS?

- To check the status of your ERA enrollment, send an email to Support@officeally.com



OPTUM 835 ENROLLMENT REQUEST

Email this form to Support@officeally.com or Fax to (360) 896-2151. Once your form is received and processed, Office Ally will email you a confirmation. If you do not receive a confirmation email from us within 2-3 business days or faxing or emailing this form, please send it again. Please make sure to print legibly and to complete this form in its entirety. You risk delaying enrollment if the application is unreadable or incomplete. All fields in **bold** are **required**.

PROVIDER INFORMATION

Provider Name:

Provider Address:

City:

State:

Zip:

PROVIDER IDENTIFIERS INFORMATION

**Provider Federal Tax Identification Number
Employer Identification Number (EIN):**

National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION

Contact Name:

Telephone Number/Extension:

Email Address:

Fax Number:

SUBMISSION INFORMATION

Reason for Submission:

Authorized Signature:

Note: Electronic Signature (Typed Name) of Person Submitting ERA Enrollment.

NOTE: If you have received ERA's from these payers through another clearinghouse, you may be prompted via email from your previous clearinghouse to confirm the change. If you do not confirm the change, enrollment will be delayed.

Payer Information					
CPID	Payer ID	Payer	Type	Est Days	Multi CH
Special Enrollment Instructions					
Vendor Information					
Submitter ID	Submitter Name				
Provider Information					
Tax ID	NPI	Provider Number	Name		
Address			City	State	Zip
Contact Name				Contact Phone	
Contact Email Address					
Confirmation Addresses					
Primary Email Address			Secondary Email Address		
ERA Receiver					
Distribution Detail					



Today's date ___/___/___

New EDI enrollment Change in EDI enrollment

Provider information (for Professional 837 we need the individual provider NPI)

Provider/group name _____ Specialty _____

Tax ID # _____ NPI # _____

Additional Tax ID #: _____

Provider address _____

City _____ State _____ ZIP _____

Remittance address _____

City _____ State _____ ZIP _____

Provider phone _____ - _____ - _____ Provider fax _____ - _____ - _____

Contact name _____ Title _____

Email _____

Transaction information

Which of the following transactions are you interested in submitting and/or receiving electronically?
Please indicate the submission and/or delivery method by checking all that apply.

	Direct submission	Clearinghouse
270/271 — Eligibility	<input type="checkbox"/>	<input type="checkbox"/>
835 — Payment/remittance advice*	<input type="checkbox"/>	<input checked="" type="checkbox"/>
837 — Claim submission	<input type="checkbox"/>	<input type="checkbox"/>

Which type of claims will you submit? Check all that apply. Professional Institutional

How do you currently submit claims to Tufts Health Public Plans?

Check all that apply. Paper Direct Clearinghouse

If you are using a clearinghouse or billing agency, who is it? CHANGE HEALTHCARE/EMDEON

EDI submission and testing contact information

Internal Name _____ Phone _____ - _____ - _____

Email _____

Vendor Name _____ Phone _____ - _____ - _____

Email _____

Questions? Email us at EDI@tufts-health.com