

WHAT ARE THE LETTER REQUIREMENTS?

Please Note: All ERA files will be routed to this username. We cannot separate payers into multiple accounts.

We only need one form on file for each NPI and Tax ID combination. This request applies to all payers.

(See Template on Page 2)

1. **Provider Letterhead**
 - **Must be on the provider, practice, or facility's unique letterhead.**
2. **New Account Username**
 - **Must be an Admin/Parent account (not a child account).**
3. **TIN & NPI(s)**
 - **List multiple NPIs if needed, but only one TIN per letter.**
4. **Effective Date**
 - **Effective Date may not be more than two weeks prior to the submission of this form.**
5. **Confirmation Email**
 - **Enter the provider's email for notifications.**
6. **Authorized Signature**
 - A handwritten signature is required (no electronic signatures).
 - Must be signed by the provider, practice/facility owner, or account owner. Signatures from billers or third-party organizations will be rejected.

WHERE SHOULD I SEND THE LETTER?

- This form must be emailed to ERATransfer@officeally.com for processing.
 - The request **MUST** come directly from the Provider/Facility. **Requests received from billers/third parties will be rejected.**
 - The provider may cc any third parties involved in the switch to ensure they are notified when processing is complete.

WHAT IS THE TURNAROUND TIME?

- Standard processing time is one week

[INSERT PROVIDER LETTERHEAD]

ERA DELIVERY CHANGE FORM

Today's Date: _____

To whom it may concern,

I, _____, hereby authorize Office Ally to deliver ERA files for the TIN and/or NPI(s) listed below to the referenced Office Ally Account Username. I understand that ERA files Office Ally receives for **all Payers** will be routed to only the username listed.

Office Ally Account Username: _____
(Cannot be Child/SA Account or Clearinghouse Name)

Tax ID/EIN: _____

NPI(s): _____

Desired Effective Date: _____
(Must be within 2 weeks of form submission)

Confirmation Email Address: _____

By signing below, I certify that I am the Provider/Provider Facility Owner for the TIN and NPI(s) listed above.

Authorized Individuals Signature
(Must be handwritten)

Printed Name of Authorized Individual

Title of Authorized Individual
(Must be Provider or Practice/Facility Owner or owner of Previous OA Account UN)