

**WHICH FORMS SHOULD I COMPLETE?**

- Complete the **Electronic Payment/Remittance Authorization Agreement**

**WHERE SHOULD I SEND THE FORM(S)?**

- Email the signed form to: [EFT\\_ERA\\_INQUIRY@SENTARA.COM](mailto:EFT_ERA_INQUIRY@SENTARA.COM) and [Availity.ERA@officeally.com](mailto:Availity.ERA@officeally.com)
  - o Email Subject Line: Optima Health BH/Sentara (5415M)\_ERA Enrollment
  - o Email Body: Please process the attached enrollment form for ERA approval.
- You will receive an auto-generated email with a case number, which will be used for tracking.

**WHAT IS THE TURNAROUND TIME?**

- Standard Processing Time can take up to 4 weeks.

**HOW DO I CHECK STATUS?**

- If after 4 weeks you do not start receiving ERA's then you may contact please email [payerenrollment@officeally.com](mailto:payerenrollment@officeally.com) with your original case number from the auto-generated email and request a status of the ERA enrollment for Payer ID 5415M.



## TRANSACTION ENROLLMENT INSTRUCTIONS

PAYER ID:

PAYER NAME:

TRANSACTIONS:    Inst. Claims    Prof. Claims    ERA    Eligibility    Claim Status

Please see below for enrollment instructions. For questions, please call our customer service center at (800) 282-4548 or you may open a support ticket through the application.

Enter Provider Information (print or type)		
Provider/Organization Name		
Provider Tax ID	Provider/Group NPI	
Availity Customer ID	Provider Legacy ID (if available)	
Provider Billing Address		
City	State	Zip
Authorized Name	Phone	
Email Address		
Online Enrollment Completed Date (if applicable)		

### Enrollment Instructions

Complete the attached forms and email to the payer at [EFT\\_ERA\\_INQUIRY@SENTARA.COM](mailto:EFT_ERA_INQUIRY@SENTARA.COM) or fax to 757-252-8037.

### Submission Instructions

Follow the instructions to enroll on the payer's paperwork and then upload the completed form in the Availity Transaction Enrollment portal. Select "Take Action" from the enrollment status page and then "Upload Enrollment Form."

## Electronic Payment/Remittance Authorization Agreement

Detailed instructions on how to complete this form can be found at <http://providers.optimahealth.com/billing/Pages/eftera-authorizationagreement.aspx>. If you have any questions, please contact Optima Finance at [EFT\\_ERA\\_INQUIRY@SENTARA.COM](mailto:EFT_ERA_INQUIRY@SENTARA.COM).

\* An asterisk denotes required information

### PROVIDER INFORMATION

\* Provider Name

### PROVIDER IDENTIFIERS INFORMATION

\* Provider Federal Tax Identification

Number (TIN) or Employer Identification Number (EIN)

Please include TIN numbers for all practice locations EFT applies to

\* National Provider Number (NPI)

### PROVIDER CONTACT INFORMATION

\* Provider Contact Name

\* Telephone Number

\* Email Address

Provider Numbers

### FINANCIAL INSTITUTION INFORMATION

\* Financial Institution Name

\* Financial Institution Routing Number

\* Type of Account at Financial Institution

Checking
  Savings

\* Provider's Account Number with Financial Institution

\* Account Number Linkage to Provider Identifier  
*(e.g., Preference for Aggregation of Remittance Data )*

\* Provider Tax Identification Number (TIN)

### ELECTRONIC REMITTANCE ADVICE INFORMATION

\* Preference for Aggregation of Remittance Data  
*(e.g., Account Number Linkage to Provider Identifier)*

\* Provider Tax Identification Number (TIN)

\* Method of Retrieval

Print from OptimaHealth.com

YOU MUST HAVE AN OPTIMAHEALTH.COM USERNAME AND PASSWORD

Optimahealth.com Login ID:

Optimabehavioralhealth.com Login ID:

If you do not have an Optimahealth.com username and password, Providers may submit a Provider Connection Enrollment Form which can be found at Optimahealth.com.

<https://www.formrouter.net/forms09@SNTRA/OptimaEnrollment.html>

Clearinghouse

Access directly from the Optima secure FTP Site

An Optima Health Finance representative will contact you to discuss specific requirements.

**ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION**

\* Clearinghouse Name

Your clearinghouse must have a relationship with the Optima Health clearinghouse of choice: Misys-Payerpath.

**SUBMISSION INFORMATION**

Please attach a letter on bank letterhead. The letter must be dated within the last 90 days and should include the physical bank address, routing and account number, a bank employee's name, title, email, and phone number.

\* Reason for Submission  New Enrollment  Change Enrollment  Cancel Enrollment

Request Type  Optima Health Plan  Optima Behavioral

With your Signature and Printed Name, 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 Agent. The Provider or Agent has sole control of the account to which EFT deposits are made in accordance with all applicable Federal regulations and instructions. All arrangements between the Financial Intuition and the said Provider or Supplier are in accordance with all applicable Federal regulations and instructions with the effective date of the EFT authorization. You must notify Optima Health in writing in regards to any changes in the account in sufficient time to allow the contractor and the Financial Institution to act on the change.

The EFT Authorization must be signed by an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment.

\* Written Signature of Person Submitting Enrollment

\* Printed Name of Person Submitting Enrollment

\* Submission Date

\* Requested EFT Start/Change/Cancel Date

\* Requested ERA Effective Date