Office Ally

OPTUM CARE NETWORK (OCN01) ERA ENROLLMENT INSTRUCTIONS

WHICH FORMS SHOULD I COMPLETE?

- **835 Electronic Remittance Advice Enrollment Form (page 2)**
- EFT is not required to receive ERA files. However, if you would also like to set up EFT, please complete the: **EFT Authorization Agreement (page 3)**
  - *Include your W-9* ***and*** *either a voided check or bank letter with EFT enrollment request*

WHERE SHOULD I SEND THE FORM(S)?

- Email the **ERA Enrollment Form** to pgcclmenrollfax36219@optum.optumcare.com
- Email the **EFT Authorization Agreement** to EFT_Enrollment@optumcare.com

WHAT IS THE TURNAROUND TIME?

- Standard Processing Time can take up to 20 business days.

HOW DO I CHECK STATUS?

- If you have not started receiving your ERA files after 20 business days from submitting the enrollment request, please email Optum Care Network to request status and confirm you are linked to Office Ally.
- The provider paper EOB is kept for **45-Calendar-Day Activation Process**, and the Provider will continue to receive both Paper EOBs and Electronic ERAs until the Activation Process is completed.

835 ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT FORM OPTUM CALIFORNIA

REQUEST TYPE (SELECT ONE): **DATE:** ____________________

☐ Select **NEW** Enrollment – Must Complete **Section 1**
If not currently receiving Electronic 835 Remittance File to Auto-Post Payments

☐ Select **CANCEL** Enrollment – Must Complete **Section 1 and 3**
Terminating receipt of the Electronic 835 Remittance File to Auto-Post Payments

Fax or Email Completed Form to Optum EDI Department:

- ✓ **EMAIL: pgcclmenrollfax36219@optum.optumcare.com**
- ✓ **FAX: (310) 352-6219**

Please **PRINT** form clearly

1. NEW ENROLLMENT	
Provider Contact Name:	Contact Number:
Contact E-mail:	Title:
Provider Name:	National Provider Identifier (NPI):
Provider Address:	TIN:
City:	State/Zip:

2. RECEIVER INFORMATION	
Receiver Name: **Office Ally, Inc.**	
Contact: **Customer Service**	
Support: **360-975-7000 – Option 1** Office Ally Support	Optum Submitter ID:

3. CANCEL ENROLLMENT
Receiver Name:
Delete Enrollment Date:

NOTE:

- The standard time to process your 835 Enrollment form is **6-10** business days.
- There's a **45-Calendar-Day Activation Process**, and the Provider will receive both Paper EOBs and Electronic ERAs until the Activation Process is completed.
- If Office Ally is not your primary Clearinghouse, please make sure your clearinghouse is connected with Office Ally.

Reason for Submission (CHECK ONE)	Electronic Funds Transfer (EFT) Authorization Agreement	Return Completed Form to:
☐ NEW Enrollment ☐ CHANGE Enrollment ☐ CANCEL Enrollment		Email: EFT_Enrollment@optumcare.com **Optum Network - HealthCare Partners**

Please complete this form to receive electronic payments for Optum affiliate(s) **HealthCare Partners, AppleCare, PMG SJ, Northern California Physicians Network, Optum Health plan of California** and **Optum Professional.** Deposits will be made to the bank account listed below. **Please PRINT clearly and complete all required information.** Please allow 7-10 working days for Electronic Funds Transfer (EFT) enrollment processing.

Provider Information (REQUIRED)

Provider Name:		
Provider Address:		
City:	State:	Zip Code/Postal Code:
Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):		

Provider Contact Information (REQUIRED)

Provider Contact Name:		Title:
Telephone Number (+Extension):	Fax Number:	Email Address:

Financial Institution Information (REQUIRED)

Type of Account at Financial Institution: ☐ Checking	
Financial Institution Name: (Attention: Bank of America may require a different routing number for e-transactions than what appears on your personal or business check. Please contact your bank to verify.)	
Financial Institution Address:	Bank Routing Number:
Financial Institution City / State / Zip Code:	Bank Account Number:

Authorized Signature (REQUIRED)

The undersigned hereby authorizes Optum affiliate(s) HealthCare Partners, AppleCare, PMG SJ, Northern California Physicians Network, Optum Health plan of California and Optum Professional (collectively referred to as "COMPANY") to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries in error to Provider checking/savings account indicated above and the bank named above to credit and/or debit the same account. The undersigned hereby certifies that the information provided herein is true and accurate in all respects and that he/she has been duly authorized by all necessary and appropriate corporation action, where applicable, to execute this agreement on behalf of the above mentioned Provider to form a legally binding contract. This Authorization is to remain in full force and effect until COMPANY has received written notification from the undersigned of its termination in such time and manner as to afford COMPANY a reasonable opportunity to act on it.

Authorized Signature:	Date:
Name:	Title:

Please include your W-9 ("New Enrollment" Only) and a copy of a voided check or bank letter with the signed enrollment form.

W-9 Notes:

- We cannot complete your enrollment without a copy of your Federal W-9, which will be used to certify the information you have provided.
- The TIN/EIN and Provider Name on this form must match the TIN/EIN number and Name or Business name listed on the Federal W-9.
- By submitting a W-9, you are certifying that the Tax Identification Number (TIN) information you are providing is true and accurate.
- If your organization does not have a completed W-9 form, please download and complete this Federal form: http://www.irs.gov/pub/irs-pdf/fw9.pdf

For internal use only:

Date Received:	____________	Date Processed:	____________
Vendor Type:	____________	Completed By:	____________
Vendor ID:	____________	Verified by:	____________