HEALTH NEW ENGLAND (04286)
ERA ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- Optum360 ERA Enrollment Form
- Change Healthcare Remittance Enrollment Form
- Health New England Online Enrollment
- 835 Enrollment Request

WHERE SHOULD I SEND THE FORM(S)?

- The **Health New England Enrollment** is completed online.
- Email the other forms to Support@officeally.com; or fax them to (360) 896-2151.

WHAT IS THE TURNAROUND TIME?

- Standard processing time is 30-40 business days.

Optum360
Electronic Remittance Advice Enrollment

Updated: 3/11/2019

Payer Name: Health New England (P)	Payer ID: 04286

Overview

Complete all forms as instructed below and return them for the additional processing necessary to set up your account for electronic remittance advice (ERA).

Estimated approval timeframe: 15-35 Business Days

Enrollment Agreement Instructions

To enroll for ERAs with Health New England (P):

1. Complete the attached Optum360 Electronic Remittance Advice Enrollment form.
2. Complete the attached payer enrollment form, which includes instructions to assist with your enrollment.

   Optum360 partners with Availity who goes through Change Healthcare to this payer for ERAs. Please follow the attached Change Healthcare instructions for enrollment with this payer. Be sure to return the Availity page that acknowledges that you have completed this enrollment.

3. Return all completed forms, along with your Optum360 Electronic Remittance Advice Enrollment form, to Optum360. Submit completed ERA Payer forms under the IEDI Enrollments tab.

   Important: Include your 8-digit ENS/Optum360 user ID on all correspondence.

Who do I contact if I have questions?

Contact the Optum360 Enrollment Department at (866) 367-9778, option 1.

Optum360
Electronic Remittance Advice Enrollment

Rev. 08.19.2016.1

Optum360 User ID: GATE0068 (Office Ally)			
PAYER INFORMATION			
Payer Name: Health New England (P)			Payer ID: 04286
RECEIVER INFORMATION			
Your ERA files will be received by the following clearinghouse:			
Receiver Name: Electronic Network Systems, Inc.			Availity Customer ID: 24932/enscommercial
Contact Name: Enrollments Department			
Telephone Number: (866) 367-9778	Ext: opt. #1	E-mail Address: enrollments@optum.com	
PROVIDER INFORMATION			**PROVIDER IDENTIFIERS INFORMATION**
Provider Name:			Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):
Street:			
City:	State/Province:	ZIP Code/Postal Code:	National Provider Identifier (NPI):
PROVIDER CONTACT INFORMATION			
Provider Contact Name:			
Telephone Number:		E-mail Address:	
ELECTRONIC REMITTANCE ADVICE INFORMATION			
Preference for Aggregation of Remittance Data	☐ Provider Tax Identification Number (TIN):		
	☐ National Provider Identifier (NPI):		
			Date:
SUBMISSION INFORMATION			
Reason for Submission:	☒ New Enrollment	☐ Change Enrollment	☐ Cancel Enrollment
Authorized Signature:			
Important: By typing or signing a name in this field, you acknowledge and agree that you have been authorized by the provider or its agent to initiate, modify, or terminate an enrollment. You further acknowledge and agree that you have the legal authority to perform such action on behalf of your organization.			
Printed Name of Person Submitting Enrollment:			Submission Date:
Internal use only:			
Optum360 Internal use only: Update ERA in IEDI Add in Availity Web Portal SEND ONLY the CHC bar code page and payer form			**Availity Internal use only:**

Send completed form to:
Batchenrollment@changehealthcare.com
Fax: (615) 885-3713

CHANGE HEALTHCARE

Remittance

Payer Information

CPID	Payer ID	Payer	Type	Est Days	Multi CH
6432	04286	HEALTH NEW ENGLAND	Professional	14	No

Special Enrollment Instructions

Health New England has an online procedure for completing agreements. Please use the instructions attached for the payor enrollment process. Once the payor enrollment process is completed, submit this agreement to Change Healthcare.

Claims must be sent before remittance can be setup.

Vendor Information

Submitter ID	Submitter Name
332211888	AVAILITY LLC

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
aacenrollment@availity.com	

ERA Receiver

Distribution Detail

AVAILITY

For Change Healthcare use only

Complete enrollment process at payers website:
https://www.hnedirect.com/eft/EFTPage1.aspx

Section A-ENROLLMENT SELECTION

Enrollment Type (Select One)
New Enrollment

EFT/ERA Option (Select One)
ERA Only

Practice Type (Select One)
Individual Provider

Provider/Group/Facility Information

Provider/Group/Facility Name *

Provider Tax ID *

Provider NPI *

Provider Contact Name *

Provider Contact Phone *

Provider Contact Email *

Billing Address *

City *

State
AL

Zip *

* Required Fields

Next

Section B-PROVIDER/VENDOR/CLEARINGHOUSE/BILLING AGENT

PLEASE SELECT WHO WILL RECEIVE THE 835 ERA ELECTRONICALLY FROM HEALTH NEW ENGLAND INC.

- ○ Provider
- ◉ Vendor/ClearingHouse/BillingAgent

HEREBY CERTIFIES TO HEALTH NEW ENGLAND, INC. THE FOLLOWING WITH RESPECT TO THE 835 ELECTRONIC REMITTANCE ADVICE:

- Provider will coordinate receipt of remittance test file(s) from the designated clearinghouse/vendor if a vendor is named.
- Provider acknowledges that it will complete the test file(s) and use the 835 ERA data for posting to their accounting systems.
- Provider will notify their EDI Vendor of their intention to begin ERA testing.
- Provider agrees that upon approval of this Certification and the initiation of routine ERA processing, Provider will no longer receive a hard copy EOR (Explanation of Remittance) after thirty (30) days from production. AR-SA.
- Provider, or an authorized representative of Provider, will notify Health New England, Inc. in writing of any changes or corrections required in the ERA process.

Providers who chose to receive 835 transactions directly from HNE may elect to return a 999 Acknowledgement file. HNE does not require this but if you do opt in, you must always transmit the acknowledgement file.

☐ Please check here if you will be sending an acknowledgement file.

Clearinghouse information

Vendor Name * Emdeon

Vendor Tax ID * 133052274

Vendor Contact Phone * 866-924-4634

☐ BY CHECKING HERE, PROVIDER AUTHORIZES HEALTH NEW ENGLAND, INC. TO TRANSMIT PROVIDER'S 835 FILES TO VENDOR *

Provider/Representative Name * Enrollment Help Desk

Vendor Name(Appointed) * Emdeon

TO ACT AS THE AUTHORIZED AGENT FOR THE PURPOSE OF RETRIEVING THE 835 ERA ELECTRONICALLY FROM HEALTH NEW ENGLAND, INC.

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* Required Fields

Section E-PROVIDER AUTHORIZATION

The undersigned Provider hereby authorizes and requests Health New England, Inc. (HNE) to effect payment for all amounts owed to the Provider by HNE as such amounts become payable. Payment shall be made by initiating entries to the Provider's account in the bank or financial institution indicated above. The Provider authorizes and requests said bank or financial institution to credit the same to such account. This authorization is active as of two weeks after HNE receives the request and shall remain in effect until terminated. The Provider may terminate this authorization without cause by giving 15 days prior written notice to HNE. HNE may terminate this authorization without cause at any time. I agree that if unearned or erroneous payment is credited to my account by HNE, I will immediately repay HNE the full amount of such unearned or erroneous pay. I also agree to allow an automatic reversal of any deposits made in error.

If you are a provider that is not participating with Health New England's Medicare Advantage product, CMS has established guidelines outlining how Health New England must process "Non-Contract Provider Appeals for Medicare Advantage." To understand the process and the provider's rights and responsibilities, please go to: http://www.healthnewengland.com/hne_providers/index-oop.html.

Name of Authorized Representative*

Date Completed

Email Address*

Verify Email Address*

Generate New Image

Type the code from the image

Submit Form

Previous

* Required Fields

Once the enrollment on the payer's website has been completed, please submit this agreement.

Provider Name:

National Provider Identifier (NPI):

Tax Identification Number (TIN):

☐ By completing and submitting this form to the Clearinghouse I am confirming the completion of the enrollment process at the payer's website.

Email

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: New ERA Enrollment

Authorized Signature:

Submit by Email

Clear Form

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.