ROCKY MOUNTAIN HEALTH PLAN (RMHMO)
ERA ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- **835 Enrollment Request**
- **Rocky Mountain Health Plan ERA Enrollment Form**

WHERE SHOULD I SEND THE FORM(S)?

- Email the **835 Enrollment Request** to Support@officeally.com or fax to (360) 896-2151
- Email the **Rocky Mountain ERA Enrollment Form** to edicoordinator@rmhp.org; Support@officeally.com

WHAT IS THE TURNAROUND TIME?

- The standard processing time is 15 business days.

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:

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

Submit by Email

Clear Form

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.

Optum360
Electronic Remittance Advice Enrollment

Rev. 08.19.2016.1

Optum360 User ID: GATE0068			
PAYER INFORMATION			
Payer Name: Rocky Mountain HMO (P)			Payer ID: 14905
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:	**Availity Internal use only:**
Update ERA in IEDI	

Provider ID:

NPI:

Tax ID:

DBQ

CHANGE HEALTHCARE

Return completed agreements to:
Change Healthcare
Attn: Enrollment Dept. (IADU-DC2)
301 Data Court
Dubuque, Iowa 52003

Payer Agreement Cover Sheet

Agreement Type: Remittance

Estimated Approval Time: 10

Multiple Clearinghouses: Yes

☐ CPID 3556	ROCKY MOUNTAIN HMO - Institutional
☑ CPID 7470	ROCKY MOUNTAIN HMO - Professional

CID

Submitter ID 392886

Submitter Name Availity LLC

Customer ID 1046700

Billing ID 392886

Reference ID

4E

Remittance

Last Revised Date: 03/28/17

ERA Enrollment Form

Instructions for completing the ERA Enrollment Form. *Signifies Required Field*

Online Enrollment: If you would like to begin receiving an 835 transaction from RMHP, go to http://www.rmhp.org/providers/commonly-used-forms, go to EDI and click on the ERA Enrollment Form. Complete all required fields, save, and email to edicoordinator@rmhp.org. (Be sure your browser supports online pdf form edits, if not, you can print and fax the form using Paper Enrollment (below))

Paper Enrollment: If you would like to begin receiving an 835 transaction from RMHP, and prefer to enroll through means other than online, go to http://www.rmhp.org/providers/commonly-used-forms, go to EDI and click on the ERA Enrollment Form. Print and complete legibly using only black or blue ink. Once completed, please fax the form to 970-244-7880, Attention: IT/EDI.

To check the status of an enrollment or to dis-enroll, please email: edicoordinator@rmhp.org

PROVIDER INFORMATION

* **Provider Name** - Complete legal name of institution, corporate entity, practice or individual provider.

* **Provider Address**

Street - The number and street name where a person or organization can be found.

City - City associated with provider address field.

State/Province - ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.

Zip Code/Postal Code - System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.

PROVIDER IDENTIFIERS INFORMATION

* **Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)** - A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.

* **National Provider Identifier (NPI)** - A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Other Identifiers

* **Assigning Authority** - Organization that issues and assigns the additional identifier requested on the form, e.g., Medicare, Medicaid.

Trading Partner ID - The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor.

Provider License Number

License Issuer - Required if License Number is collected.

PROVIDER CONTACT INFORMATION

* **Provider Contact Name** - Name of a contact in provider office for handling ERA issues.

* **Telephone Number** - Associated with contact person.

* **Email Address** - An electronic mail address at which the health plan might contact the provider.

ELECTRONIC REMITTANCE ADVICE INFORMATION

* **Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)**. Provider preference for grouping (bulking) claim payment remittance advice - must match preference for EFT payment.

* **Provider Tax identification Number (TIN)** - Numeric, 9 digits (Optional - required if NPI is not applicable)

* **National Provider Identifier (NPI)** - Numeric, 10 digits (Optional - required if TIN is not applicable)

* **Method of Retrieval** - The method in which the provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.). Optional (Required if the provider is not using an intermediary clearinghouse or vendor).

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

* **Clearinghouse Name** - Official name of the provider's clearinghouse.

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION

* **Vendor Name** - Official name of the provider's vendor.

SUBMISSION INFORMATION

* **Reason for Submission; select from below.**

New Enrollment

Change Enrollment

Cancel Enrollment

ERA Enrollment Form

PROVIDER INFORMATION

Provider Name *

Provider Address

Street *
City *
State/Province *
Zip Code/Postal Code *

PROVIDER IDENTIFIERS INFORMATION

Provider Identifiers

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) *
National Provider Identifier (NPI) *

Other Identifier(s)

Assigning Authority *	N/A
Trading Partner ID	MCKESSON9

Provider License Number

License Issuer *	N/A

PROVIDER CONTACT INFORMATION

Provider Contact Name

Contact *
Telephone Number *
Email Address *

ELECTRONIC REMITTANCE ADVICE INFORMATION

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

Provider Tax Identification Number (TIN) *
National Provider Identifier (NPI) *
Method of Retrieval - The Method in which the provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.) * Clearinghouse

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

Clearinghouse Name *	McKesson

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION

Vendor Name *	N/A

SUBMISSION INFORMATION

Reason for Submission * (Select from below)

[x] New Enrollment [ ] Change Enrollment [ ] Cancel Enrollment
Authorized Signature *
Submission Date:
Requested ERA Effective Date (Date the provider wishes to begin ERA; per Phase III CORE Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0: there may be dual delivery period depending on whether the entity has such an agreement with its trading partner.