SENTARA HEALTH/OPTIMA HEALTH (54154)
ERA ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- Emdeon ERA Provider Information Form
- Emdeon ERA Provider Setup Form
- Optum ERA Setup Form
- Sentara/Optima Health Electronic Payment/Remittance Authorization Agreement

WHERE SHOULD I SEND THE FORM(S)?

- Email the Emdeon and Optum ERA forms to enrollments@optum.com or Fax them to (877) 630-2064.
- Fax the Sentara/Optima Health ERA form to (757) 252-8037; or Mail to:

  Optima Health Plan – Attn: ERA Enrollment
  4456 Corporation Lane, Suite 350
  Virginia Beach, CA 23462

WHAT IS THE TURNAROUND TIME?

- The enrollment process takes 30 business days approximately.

HOW DO I CHECK ON STATUS?

- To check status of your ERA enrollment, email EFT_ERA_INQUIRY@SENTARA.COM

PAYER ID: 54154 SUBMITTER ID:

Emdeon ERA Provider Information Form

*This form is to ensure accuracy in updating the appropriate account

1 Provider Organization

Practice/ Facility Name		**Provider Name**			
Tax ID		**Client ID**		**Site ID**	F042
Address		**City/State**		**Zip Code**	
Contact Name					
E-mail Address		**Telephone**		**Fax**	

2 Vendor *(Emdeon certified vendor used to submit files to Emdeon)*

Vendor Name	Electronic Network Systems, Inc.	**Vendor Submitter ID**	841162789	**Division ID**	
Contact Name	Enrollments Department				
E-mail Address					

3 Payer

Payer ID	54154 Sentara Health Management	
Group ID	**Individual Provider ID**	**NPI ID**

4 Confirmations

Send Emdeon Claim Confirmations To:	

Special Instructions:

- OptimaHealth form goes directly to the payer not to Emdeon.

EMDEON REVISION FORM DATE:

Emdeon ERA Provider Setup Form

Email: batchenrollment@emdeon.com Fax: (615) 885-3713

1 Provider Organization

Practice/Facility Name					
Tax ID		Billing NPI ID			
Practice/Facility Address					
	City		State		Zip Code	
Contact Name		Contact Phone Number			
Provider Email					

2 Vendor (Emdeon contracted & certified customer used to retrieve ERA files)

Vendor Name	Electronic Network Systems, Inc.	Submitter ID	841162789
Contact Name	Enrollments Department	Contact Phone Number	866-367-9778

3 ERA Receiver

Receiver ID	841162789		
Distribution Method (Must list one method)	FTP Internet Log In ID (8 characters)	Distribution	ENSHEALT

4 Payer (If additional rows are required for payer ID selection, complete additional ERA Provider Setup Forms.)

Following Payers MUST have Legacy ID's listed to complete Payer Enrollment: SB580-SB690-SKAR0-SKMD0

Payer ID	Group ID	Individual ID	NPI ID	Payer ID	Group ID	Individual ID	NPI ID
54154							

5 Confirmations (Enter E-mail address)

enrollments@optum.com

Confirmations (Enter E-mail address)

Section 1 Provider Organization section must be fully completed with Facility/Provider information, failure to complete all fields may result in form rejections. Do not list Vendor or Billing Service information. ERA payer enrollment requires that this information be that of the Facility/Provider as multiple payers will contact the Facility/Provider contact to confirm enrollment. These payers will not accept the confirmation of enrollment from Vendors or Billing Services. Billing NPI is required to complete enrollment.

PLEASE MAKE NOTE THAT THIS COV (CHANGE OF VENDOR) ONLY PROCESSES AT EMDEON. THIS FORM WILL CHANGE YOUR VENDOR CONNECTION WITH EMDEON AND DOES NOT CHANGE THE CLEARINGHOUSE LINKED WITH THE ANY PAYERS. THIS INFORMATION WILL NOT UPDATE WITH ANY PAYERS DIRECTLY NOR CHANGE WHERE THE PAYER SEND YOUR ERA FILES

For Internal Optum use only:
Enroll in Emdeon Vision Suite
If COV Ltr - Fax to : 615-885-3713
Est. approval – 30 Business Days
Check Status: EFT_ERA_Inquiry@sentara.com

OPTUM ERA Setup Form

Please complete the requested information below. This information will be used to ensure your agreements are setup and processed in the most efficient manner. This form is for Optum use only and will not be forwarded on to the payer with your enrollment agreements.

Optum user ID:	GATE0068
Contact Name:	
Group Name:	
Group Billing TIN:	
Group Billing NPI:	
Group Legacy ID:	
Taxonomy Code:	

Please list all providers for this Payer below:

Provider Name	Individual PTAN or Legacy ID (if applicable)	Individual NPI	Payer Name

OptimaHealth

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.

* *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)

PLEASE NOTE THAT BY CHOOSING TO RECEIVE YOUR PAYMENTS ELECTRONICALLY, REMITS WILL ALSO BE DELIVERED ELECTRONICALLY AND YOU MUST SELECT ONE OF THE OPTIONS BELOW. PAPER REMITS WILL CEASE.

* 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)

(X) 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 EMDEON

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

SUBMISSION INFORMATION

* Reason for Submission ( ) New Enrollment ( ) Change Enrollment ( ) Cancel Enrollment

( ) Voided Check
A voided check is attached to provide confirmation of Identification/Account Numbers.

( ) Bank Letter
A letter on bank letterhead that formally certifies the account owners routing and accounting numbers is attached.

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 _____