PROSPECT MEDICAL GROUP (PROSP) EDI-ENROLLMENT INSTRUCTIONS

WHICH FORMS SHOULD I COMPLETE?

- Complete the Electronic Remittance Advice Enrollment Form (page 2-3)

WHERE SHOULD I SEND THE FORM(S)?

- Email completed form to ERAenrollment@prospectmedical.com

WHAT IS THE TURNAROUND TIME?

- Standard Processing Time is 5/7 Business Days.

HOW DO I CHECK STATUS?

- If you do not begin receiving your ERA files after 7 business days, please reply to the original email to the payer and ask for a status update.

PROSPECT MEDICAL

Electronic Remittance Advice Enrollment Form

Processing time is 5-7 business days

Return completed form to: ERAenrollment@prospectmedical.com

PROVIDER INFO

Name:					
Address:					
City:		State:		Zip/Postal Code	

PROVIDER IDENTIFIERS

Tax Identification Number (TIN/EIN):	National Provider Identifier:

PROVIDER CONTACT INFO

Contact Name:				Title:	
Telephone:		Extension:		Email:	

ERA AGGREGATION PREFERENCE:

Provider preference for grouping claim payment remittance advice

☐ Provider Tax Identification Number (TIN) ☐ National Provider Identifier (NPI)

CLEARINGHOUSE INFORMATION

Clearinghouse Name: Office Ally

SUBMISSION REASON

☐ NEW Enrollment ☐ CHANGE Enrollment ☐ CANCEL Enrollment

The undersigned hereby certifies that the information provided herein is true and accurate in all respects and that the person 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. The undersigned authorizes Prospect Medical Systems (PMS) on its behalf and on behalf of its contracted medical groups to transmit electronic remittance advice (ERA) detail for claims processed by PMS to the provider listed above. In addition, the undersigned hereby agrees that upon completion of enrollment processing, PMS will concurrently send paper remittance and ERA for a period of 31 calendar days, after which time provider will only receive ERA. This Authorization is to remain in full force and effect until PMS has received written notification from Provider of its termination in such time and manner as to afford PMS a reasonable opportunity to act on it.

Authorized Signature: _____ Date: _____

_____ _____

Printed Name of Authorized Signature Title

PROSPECT MEDICAL

Electronic **R**emittance **A**dvice (ERA)

Enrollment Form Instructions

Provider Info

Provider Name: Enter legal name for institution, practice or provider

Provider Address: Enter physical street address, City, State, and Zip code

Provider Identifiers

TIN/EIN: Enter provider's Federal Tax Identification Number or Employer Identification Number

NPI: Enter provider's National Provider Identifier

Provider Contact Info

Contact Name: Enter the name of an individual who can be contacted about ERA enrollment

Telephone: Enter telephone number for provider contact **Extension**: Enter phone extension (*if applicable*)

Email: Enter email address for provider contact

ERA Aggregation Preference

TIN Aggregation: Selection designates ERA to be aggregated by TAX Identification Number

NPI Aggregation: Selection designates ERA to be aggregated by National Provider Identification Number

Clearinghouse Information:

Clearinghouse Name: Enter Clearinghouse Name that will receive ERA

Submission Reason:

New Enrollment – select this option to enroll in ERA for the first time

Change Enrollment – select this option to edit/modify existing ERA enrollment

Cancel Enrollment – select this option to terminate any future ERA transmissions

Signature

Authorized Signature: Signature of person authorized, to initiate, modify, or terminate enrollment on behalf of provider.

Date: Enter the date on which the enrollment is submitted.

Printed Name: Enter the printed name of person signing the ERA enrollment form