SOUTH FL COMMUNITY CARE NTWK (59064/59065) ERA ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- South Florida Community Care Network (SFCCN) Electronic Remittance Advice (ERA) Authorization Agreement

WHERE SHOULD I SEND THE FORM(S)?

- Fax the form to (406) 449-0190

HOW DO I CHECK STATUS?

- Send an email to hewenrollment@availity.com (include your NPI and Office Ally's Submitter ID ET01) and request a status update.

South Florida Community Care Network (SFCCN)
Electronic Remittance Advice (ERA)
Authorization Agreement

ERA ENROLLMENT FORM INSTRUCTIONS

PROVIDER INFORMATION

- **Provider Name** – Enter your business/entity name.
- **Doing Business As Name (DBA)** – If applicable, the alternate business name the provider/office/facility might be conducting business under.
- **Provider Address** –
  ***Use your physical office/facility address.*
  - **Street –** Enter the number and name where your office/facility is located, including any applicable suite number.
  - **City –** Enter the city for your office/facility.
  - **State/Province –** Enter the 2 character state code for your office/facility.
  - **Zip Code/Postal Code –** Enter the 5 or 9 digit zip code for your office/facility.

PROVIDER IDENTIFIERS INFORMATION

- **Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)** – Enter your Billing Tax ID Number, which can be a Social Security Number (SSN) or an Employee Identification Number (EIN).
- **National Provider Identifier (NPI)** – Enter your Billing NPI.
- **Assigning Authority –** This is defaulted to "HeW".
- **Trading Partner ID** – Enter your assigned HeW Submitter ID that this provider/office/facility is located under. If you submit claims through a Billing Agency or Clearinghouse, please acquire this information from them in order to complete the form.

PROVIDER CONTACT INFORMATION

- **Contact** – Enter the name of a contact person that can be reached for ERA questions at your office/facility.
- **Telephone Number** – Enter your contact's phone number.
- **Telephone Number Extension** – If applicable, enter your contact's phone extension.
- **Email Address** – Enter your contact's email address.

PROVIDER AGENT INFORMATION

***Required if using a Billing Agency or Clearinghouse*

- **Provider Agent Name** – Enter the name of your Billing Agency/Clearinghouse.
- **Provider Agent Contact Name** – Enter the name of the contact person from your Billing Agency/Clearinghouse that can be reached for ERA questions.
- **Telephone Number** – Enter the contact's phone number.
- **Email Address** - Enter the contact's email address.

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Bridging Healthcare Connections

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 with your payer. Please select only one of the two options below.*
  - **Provider Tax Identification Number (TIN) –** Enter this selection, if it matches your EFT payment preference. A TIN number can be a Social Security Number (SSN) or an Employee Identification Number (EIN).
  - **National Provider Identifier (NPI)** - Enter this selection, if it matches your EFT payment preference.

  **If you are enrolling in EFT (separate enrollment form) you must contact your Financial Institution to arrange for the delivery of the CORE required minimum CCD+ Data elements necessary for successful re-association of the EFT files to their corresponding ERA files. For additional information regarding these fields please refer to http://support.availity.com/articles/FAQ/EFT-CORE-Requirement-Data-to-Provide-to-Your-Financial-Institution/*

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

***Required if claims for this payer are sent to HeW from a clearinghouse. If you are submitting claims for this payer directly to HeW, then this section is not required.*

- **Clearinghouse Name** – Enter the name of the Clearinghouse that submits your claims for this payer to HeW.

SUBMISSION INFORMATION

- **Reason for Submission** –
  **Select only one*
  - **New Enrollment** – Select this option if you have not received ERAs from this payer before.
  - **Change Enrollment** – Select this option if you are receiving ERAs but are changing submitters.
  - **Cancel Enrollment** – Select this option if you are canceling your ERA enrollment altogether. This selection will completely discontinue your receipt of ERA files.
- **Authorized Signature –**
  - **Written Signature of Person Submitting Enrollment** – Please print the completed enrollment form and have the provider or authorized individual sign the form confirming their ERA request.
  - **Printed Name of Person Submitting Enrollment** – Print the name of the individual signing this form.
  - **Submission Date** – Enter the date you are submitting this form.

2525 Colonial Drive, Suite A • P.O. Box 1540 • Helena, MT 59624
P 877.565.5457 F 406.449.0190

South Florida Community Care Network (SFCCN)
Electronic Remittance Advice (ERA)
Authorization Agreement

Complete all required (*) fields and any that are required if applicable (**) on both pages of this form.

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PROVIDER INFORMATION (DEG 1)					
***Provider Name:**					
***Doing Business As Name DBA:**					
***Provider Address**	*Street:				
	*City:		*State/Province:		
	*ZIP Code/Postal Code:				

PROVIDER IDENTIFIERS INFORMATION (DEG 2)			
***Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):**		***National Provider Identifier (NPI):**	
***Assigning Authority:**	**HeW**	***Trading Partner ID:**	ET01 (OA)

***PROVIDER CONTACT INFORMATION (DEG 3)**				
***Provider Contact Name:**	*Contact:			
	*Telephone Number:		Telephone Number Extension:	
	*Email Address:			

****PROVIDER AGENT INFORMATION (DEG 4)** **(Required, if using a Billing Agency or Clearinghouse.)**		
***Provider Agent Name:**	Office Ally (Clearinghouse)	
***Provider Agent Contact Name**	*Contact	Customer Service
	*Telephone Number:	360-975-7000 Option 1
	*Email Address:	Support@officeally.com

ELECTRONIC REMITTANCE ADVICE INFORMATION (DEG 7)		
***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. Please enter into only one of the two options below.*		
Provider Tax Identification Number (TIN):	**OR**	*National Provider Identifier (NPI):*

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Complete all required (*) fields and any that are required if applicable (**) on both pages of this form.

****ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION (DEG8)** **(Required, if this payer's claims are sent through a Clearinghouse other than HeW.)**		
***Clearinghouse Name:**	Office Ally	
SUBMISSION INFORMATION (DEG10)		
***Reason for Submission:**	☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment	
***Authorized Signature**	*****Written Signature of Person Submitting Enrollment:*	(Print & Sign Here)
	*****Printed Name of Person Submitting Enrollment:*	
	*****Submission Date:* CCYYMMDD	

FORM SUBMISSION:

Completed forms can be faxed to HeW at 1-406-449-0190 or mailed to HeW, P.O. Box 1540, Helena, MT, 59624-1540.

FORM QUESTIONS:

Please review the ERA ENROLLMENT INSTRUCTIONS at the beginning of this document or contact the HeW Enrollment Department via phone at 1-877-565-5457, option 1, or via email at hewenrollment@availity.com.

APPROVAL REQUESTS:

Please submit an email with the provider NPI and your HeW Submitter ID to hewenrollment@availity.com.