



## SENTARA HEALTH/OPTIMUM HEALTH (54154) ERA ENROLLMENT INSTRUCTIONS

### WHICH FORM(S) SHOULD I DO?

- **Optum 835 Enrollment Form**
- **Change Healthcare ERA Enrollment**
- **Electronic Payment/Remittance Authorization Agreement**

### WHERE SHOULD I SEND THE FORM(S)?

- Fax ALL forms to (360) 896-2151

### WHAT IS THE TURNAROUND TIME?

- Standard processing time is 24-27 business days

### HOW DO I CHECK STATUS?

- To check the status of your ERA enrollment, send an email to [Support@officeally.com](mailto:Support@officeally.com)



# OPTUM 835 ENROLLMENT REQUEST

Email this form to [Support@officeally.com](mailto: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:**

**Authorized Signature:**

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.



# Optum360 Electronic Remittance Advice Enrollment

Updated: 3/9/2020

Payer Name:	Payer ID:
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## 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: \_\_\_\_\_

## Enrollment Agreement Instructions

To enroll for ERAs with \_\_\_\_\_:

1. Complete the attached payer enrollment form, which may include instructions to assist with your enrollment.

2. In IEDI go to Utilities > ERA Enrollment > ERA Enrollment File Upload > ERA Enrollment Instructions. This will give you the guidelines to complete a file upload.
3. Next choose the Enrollments tab.
4. Click on +New ERA Enrollment to select your ERA Form from your computer to be file uploaded.
5. **File upload just the completed Change Healthcare Remittance and payer forms to Optum360. Do not include this instruction page.**

### Who do I contact if I have questions?

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

Payer Information					
CPID	Payer ID	Payer	Type	Est Days	Multi CH
Special Enrollment Instructions					
Vendor Information					
Submitter ID	Submitter Name				
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		
ERA Receiver					
Distribution Detail					

## 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)

\* 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>)

☐ 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

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 Institution 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

**Print Form** **Save Form**

**Reset/Clear Form**