

# STATE FARM (31053) ERA ENROLLMENT INSTRUCTIONS



## WHICH FORM(S) SHOULD I DO?

- [Emdeon EnrollNow \(Click here\)](#)
  - **NOTE:** This is completed online.
  - Office Ally supports only the payers listed on the Emdeon ERA Enrollment form below. Do not choose payers that are listed on the Emdeon ERA Enrollment form when completing the EnrollNow online form.
- **Emdeon ERA Enrollment Form**
- **State Farm Authorization Agreement**
  - **NOTE:** Providers must enroll form EFT in order to receive ERAs.

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

- **Emdeon EnrollNow:** Once completed online, click Submit.
  - **NOTE:** If the payer you're enrolling for is not listed on this webpage, just enter the provider information and click Submit. The payer information will be entered on the Emdeon ERA Enrollment form.
- **Emdeon ERA Enrollment Form:** Once completed, save and email to [support@officeally.com](mailto:support@officeally.com)
  - Make sure that the email subject is: **Emdeon ERA Enrollment**
- **State Farm Authorization Agreement:** Once completed, mail or fax to

**State Farm Insurance Companies**  
**ATTN: Karen Kistner – B2**  
**One State Farm Plaza**  
**Bloomington, IL 61761-0001**  
**Fax: (309) 735-6200**

## WHAT IS THE TURN AROUND TIME?

- Once Office Ally receives your **Emdeon ERA Enrollment Form**, we will process the request within 24-48 hours.
- The time it takes ERAs to start coming through is dependent upon that individual payer. Generally, ERA's can take anywhere from 14 to 45 days to begin coming through.

## HOW CAN I CHECK THE STATUS OF MY ERA ENROLLMENT?

- To check the status of the **835 Enrollment Request Form**, please email or call Office Ally's Customer Support Department at [support@officeally.com](mailto:support@officeally.com) or (360) 975-7000 option 1.
  - Make sure to provide the **Payer, TIN/EIN** and **NPI** that was submitted on the form when you contact us.

# EMDEON ERA ENROLLMENT FORM



In order to enroll to receive ERAs electronically from this payer, please fill out this form and return it via email to [Support@officeally.com](mailto:Support@officeally.com), the Email Subject should read: **Emdeon ERA Enrollment**.

## PAYER INFORMATION OF THE PAYER YOU ARE ENROLLING FOR ERAS FROM:

STATE FARM - PAYER ID 31053

## PROVIDER INFORMATION:

**Provider Name:**

**Provider Address:**

## PROVIDER IDENTIFIERS INFORMATION:

**Provider Federal Tax Identification Number (TIN)**

**OR Employer Identification Number (EIN):**

**National Provider Identifier (NPI):**

## PROVIDER CONTACT INFORMATION:

**Provider Contact Name:**

**Telephone Number:**

**Email Address:**

## ELECTRONIC REMITTANCE ADVICE INFORMATION:

**Preference for Aggregation  
of Remittance Data:**

***Note:** Account Number Linkage to Provider Identifier. Must match preference for EFT payments.*

## SUBMISSION INFORMATION:

**Reason for Submission:**

**Authorized Signature:**

***Note:** Electronic Signature (typed name) of Person Submitting ERA Enrollment.*

**Instructions for Completing State Farm-Health Authorization Agreement  
Payer ID 30153**

**PLEASE TYPE OR PRINT CLEARLY**

**Type of Request – enter “X” to advise whether this request is a New, Change, or Delete:**

- New – new authorization
- Change – change to an existing authorization
- Delete – terminating an existing authorization

**Enter “X” to advise whether, request is for ERA, EFT, or both:**

- ERA – HIPAA 835 Electronic Remittance Advice
- EFT – Electronic Funds Transfer

**Health Care Provider Name  
Federal Tax ID  
National Provider ID  
Contact Name/Title  
Contact Email  
Business Phone  
Business Fax**

Information related to the provider requesting the ERA/EFT process with State Farm (Health), through Emdeon.

**If you wish to sign up for EFT, please complete the following section.**

**Financial Institution Name  
Street/City/State/Zip  
Phone Number**

The Health Care Provider’s bank name, address, phone number.

**Routing/ACH Number:**

This is the Health Care Provider’s bank Transit Routing/ABA number. Find this number on your business check or by contacting your bank. Deposit Slips or Routing numbers that begin with “5” may not be used.

**Account Number:**

This is the Health Care Provider’s Checking or Savings account number. State Farm (Health) will use this account to deposit EFT claim payments. Please indicate the **Type of Account** with an “X” in either Checking or Savings.

**A voided check or letter from the Health Care Provider’s bank, indicating the Routing and Account number, is necessary to set up the EFT process.**

**A signature is required, along with the name/title and date, typed or printed.**

**Send To**

**Emdeon** - Emdeon ERA Provider Information Form, according to instructions on the form.

**State Farm** – State Farm’s Authorization Agreement, Emdeon ERA Provider Information Form, and voided check or bank letter (if signing up for EFT) to:

State Farm Insurance Companies  
One State Farm Plaza  
Bloomington, IL 61761-0001  
ATTN: Karen Kistner – B2  
**OR**  
Fax to 309-735-6200  
ATTN: Karen Kistner

\*\*\*Payer ID 31053 is assigned to State Farm’s Individual Health Division only. \*\*\*



State Farm®

## Authorization Agreement Health Division

Type of Request:  New  Change  Delete  ERA  EFT

Health Care Provider Name: \_\_\_\_\_

Federal Tax ID: \_\_\_\_\_ National Provider ID: \_\_\_\_\_

Contact Name/Title: \_\_\_\_\_

Contact Email: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Business Fax: \_\_\_\_\_

**Electronic Funds Transfer (EFT)** *All Fields Are Required*

Financial Institution Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP Code: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Routing/ACH Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Type of Account:  Checking  Savings

*NOTE: Voided Check or a Letter from the Bank is required for EFT*

I hereby authorize State Farm Mutual Automobile Insurance Company, its affiliates and subsidiaries ("State Farm®") to initiate credit entries into my account as identified by the attached check or bank letter.

This authorization is to remain in effect until revoked by us in writing to State Farm Insurance.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

*Mail or Fax this form along with  
Voided Check or Bank Letter to:*

**State Farm Insurance Companies  
One State Farm Plaza  
Bloomington, Illinois 61761-0001  
ATTN: Karen Kistner B2  
FAX: 309-735-6200**