

## T2017 West ERA Enrollment Form Completion Guidelines

### Instructions for completing the ERA Enrollment form

- Please type or print legibly.
- Use only black or blue ink to complete paper form.
- Return pages 3 & 4 to:

T2017 TRICARE® West EFT  
PO Box 870156  
Surfside Beach, SC 29587-9756  
Secure Fax: 1-888-282-2841

### Provider Information - Please fill out completely

**Provider Name** - Complete legal name of institution, corporate entity, practice or individual provider.

#### **Provider Address**

**Street** - The number and street name where a person or organization can be found.

**City** - City associated with provider address field.

**State/Province** - ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country

**Zip Code/Postal Code** - System of postal zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery) and exploit electronic reading and sorting capabilities.

### Provider Identifiers

**Provider Federal Tax Identification Number (TIN)** - A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.

**National Provider Identifier (NPI)** - A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

### Other Identifiers

**Assigning Authority** - Organization that issues and assigns the additional identifier requested on the form

**Trading Partner ID** - The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor

### Provider Contact Information

**Provider Contact Name** - Name of a contact in provider office for handling EFT issues

**Telephone Number** - Associated with contact person

**Email Address** - An electronic mail address at which the health plan might contact the provider

**Fax Number** - A number at which the provider can be sent facsimiles

**Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)** -

Provider preference for grouping (bulking) claim payments – must match preference for EFT payment

Must fill out one of the two options below:

**Providers Tax Identification Number (TIN)**

**National Provider Identifier (NPI)**

**Clearinghouse Information**

**Clearinghouse Name** - Official name of the provider's clearinghouse

**Telephone Number** - Telephone number of contact

**Email Address** - An electronic mail address at which the health plan might contact the provider's clearinghouse

**Reason for Submission:** Must select one from below

**New Enrollment**

**Change Enrollment** - write a note stating the needed change and the requested ERA effective date of the change.

**Cancel Enrollment** - provide requested ERA effective date of the cancellation.

**Authorized Signature** - The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment may be used with electronic and paper-based manual enrollment

**Written Signature of Person Submitting Enrollment** - A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity

**Printed Name of Person Submitting Enrollment** - The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment

**Printed Title of Person Submitting Enrollment** - The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment

**Submission Date** - The date on which the enrollment is submitted

**Requested ERA Effective Date** - Date the provider wishes to begin ERA; per Phase III CORE Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0: there may be a dual delivery period depending on whether the entity has such an agreement with its trading partner

## T2017 West ERA ENROLLMENT FORM

PROVIDER INFORMATION					
Provider Name					
Street					
City		State		ZIP Code/ Postal Code	
PROVIDER IDENTIFIERS INFORMATION					
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)					
National Provider Identifier (NPI)					
Other Identifiers Assigning Authority		Trading Partner ID	7GW		
<input type="checkbox"/> <b>NOTE:</b> Checking this box indicates enrolling <b>all</b> locations for this provider's TIN/EIN that are active in our provider files and will no longer receive a paper remit. Otherwise, if only <b>specific</b> locations are to be included, list them below. <b>Attach additional sheets if necessary.</b>					
TRICARE Provider Number (with suffix)	National Provider Identifier (NPI)	Business Name and Address			
PROVIDER CONTACT INFORMATION					
Provider Contact Name					
Telephone Number		Fax Number			
Email Address					
Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier) (Must match EFT Preference)		<input type="checkbox"/> Provider Tax Identification Number (TIN) _____			
		<input type="checkbox"/> National Provider Identifier (NPI) _____			
Method of Retrieval (Required if provider is not using clearinghouse or vendor)					

<b>ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION</b>			
Clearinghouse Name			
Telephone Number			
Email Address			
Reason for Submission	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Enrollment <input type="checkbox"/> Cancel Enrollment		
<b>AUTHORIZED SIGNATURE</b>			
Electronic Signature of Person Submitting Enrollment			
Printed Title of Person Submitting Enrollment			
Submission Date		Requested ERA Effective Date	