WEA INSURANCE GROUP (39151)
ERA ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- ERA/ EFT Enrollment Form
- Optum ERA Provider Setup Form

WHERE SHOULD I SEND THE FORM(S)?

- Email the **ERA and EFT Enrollment Form** to EDI_835ACHenrollment@weatrust.com ; enrollments@optum.com
- Email the **Optum ERA Provider Setup Form** to support@officeally.com

WHAT IS THE TURNAROUND TIME?

- Approximately 15-20 business days

WEA trust
45 Nob Hill Road, P.O. Box 7338 | Madison, Wisconsin 53707-7338
800.279.4000 WEAtrust.com

ERA/EFT

Electronic remittance advice and electronic funds transfer. A convenient way to manage your finances.

What is an ERA/EFT?

ERA is a HIPAA-compliant electronic communication that contains claims payment information. It replaces the paper remittance advice statement. Depending on your accounts receivable software, you may be able to post payments electronically without any manual intervention.

EFT offers you a secure, efficient process for electronically depositing claims payments into your bank account(s).

The ERA is available for all WEA Trust benefit plans. Your current payment frequency will not change. Our ERA/EFT options are available to both participating and non-participating providers.

Benefits of enrolling in WEA Trust ERA/EFT

When you choose electronic delivery of your claims payment information and funds, you can:

- Automate your posting processes and financial management
- Receive confidential and secure deposit of payments directly to a designated account(s) quickly and efficiently
- Manage your business more effectively with a convenient audit trail

Getting started is easy

1. Complete the form
2. Attach a voided check or letter from your financial institution (optional)
3. Send the completed form via email to EDI_835ACHEnrollment@weatrust.com
4. We will contact you by email to confirm receipt and outline next steps

Please check the appropriate boxes:

Initial Enrollment Request ☐ (Complete the entire portion of the form on page 2)

Change Clearing House ☐ (Complete Sections 1 and 2 of the form on page 2)

Change Bank Information ☐ (Complete Sections 1 and 3 of the form on page 2)

Termination ☐

Section 1. Please complete the following information: (Note: incomplete fields may result in processing delays)

Practice Information

Name:	Federal Tax Identification Number (TIN): National Provider Identifier (NPI):
Contact Name:	Email Address:
Phone Number:	Fax Number:
Primary Service Address:	Primary Billing Address:

Section 2. ERA Vendor/Clearinghouse Information

Name: Electronic Network Systems, Inc

Contact Name: Enrollments Department

Email Address: enrollments@optum.com Contact Phone Number: (866) 367-9778 Option 1

Section 3. Please complete the following bank account information for EFT:

To take advantage of direct deposit (EFT), your bank must be a participating member of the Automated Clearinghouse Association (ACH). Please note that if you require payments to be deposited into multiple bank accounts, you must complete bank account information for each account. You are responsible for notifying WEA Trust if your banking information changes.

Financial Institution (FI) Name: _____

Street, City, State, Zip Code: _____

Account Number: _____

FI Routing Number: (9 digits found on check, NOT deposit slip): _____

Account Type: _____

Authorization Agreement for Direct Deposit of Benefits Payments. Please read and sign your name below.

I hereby authorize WEA Insurance Corporation, (hereinafter "WEA Trust"), to initiate credit entries to the account(s) at the bank(s) listed above for all benefits payments. This agreement will remain in effect until I notify WEA Trust of the desire to cancel or change this service, or until WEA Trust notifies me that this service has been terminated. I understand that I must allow reasonable time for my instructions to be executed. If WEA Trust credits more money than the correct benefits amount to the account due to duplicate electronic funds transfers (where "duplicate" is defined as multiple electronic funds transfers received for the same services rendered, the same membership and the same dates of service) or erroneous electronic funds transfers (where "erroneous" is defined as complete electronic funds transfers received in error), I authorize WEA Trust to withdraw the overpayment. I authorize and request the bank(s) listed above to accept any credit entries by WEA Trust to such account(s) and to credit the same to such account(s).

Electronic Signature

Checking the "I Agree" box is your legal signature for purposes of electronic online ERA/EFT enrollment. If you agree to the above terms and conditions, including Authorization for Direct Deposit of Benefits Payments, check the "I Agree" box.

☐ I Agree/Authorized Health Care Professional: _____ Date: _____

Form Completed by:

Name: _____

Phone Number: _____ Fax Number: _____ Email Address: _____

835 ENROLLMENT REQUEST

Email this form to support@officeally.com or Fax to (360) 896-2151. Once your form is received and processed Office Ally will e-mail or call you. If you do not receive a confirmation e-mail/call from us within 2-3 days of faxing this form to us, please fax 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:

ELECTRONIC REMITTANCE ADVICE INFORMATION (CHECK ONLY ONE)

Preference for Aggregation of Remittance Data: (i.e. Account Number Linkage to Provider Identifier). Note: Provider Preference for grouping (bulking) claim payment advice. Must match preference for EFT payment (i.e. Billing Provider). Choose and fill in only **one**.

☐ Provider Federal Tax Identification Number (TIN):

☐ National Provider Identifier (NPI):

SUBMISSION INFORMATION

Reason for Submission: New ERA Enrollment

Authorized Signature:

Note: Electronic Signature (Typed Name) of Person Submitting ERA Enrollment.

Submit by Email

Clear Form