835 ENROLLMENT REQUEST
(Arrowhead Regional Medical Center - ARMC)

Email this completed form to edisupport@allcaretoyou.com. 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.

PROVIDER INFORMATION:

Provider Name:

Provider Address:

PROVIDER IDENTIFIER INFORMATION:

Provider Federal Tax Identification Number (TIN) OR Employer Identification Number (EIN):

National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION:

Provider Contact Name:

Telephone Number:

Fax 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: New ERA Enrollment

Submit by Email

Authorized Signature:

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