

WHICH FORMS SHOULD I COMPLETE?

- **ECHO EFT/ERA Enrollment Form**
 - o Follow instructions at the top of the form.
 - o Only ONE Payer can be listed on each Echo Enrollment form. If you would like to enroll with multiple Payers, multiple forms must be submitted.

WHERE SHOULD I SEND THE FORM(S)?

Email To: EDI@EchoHealthInc.com

Mail To: ECHO Health Inc.
810 Sharon Dr
Westlake, OH, 41145

WHAT IS THE TURNAROUND TIME?

The Time it takes ERAs to start coming through to Office Ally is dependent upon each individual Payer. Generally, ERAs can take anywhere from 14-45 business days to begin coming through.

HOW DO I CHECK STATUS?

To check the status of your enrollment request, please contact ECHO at 440-835-3511 or by email at EDI@EchoHealthInc.com

ONLY ONE PAYER CAN BE LISTED PER ENROLLMENT FORM

Payer ID	Payer Name	Payer ID	Payer Name
72467	ACS Benefit Services	MIMCS	CareSource of Michigan Medicaid
128CA	Aetna Better Health of California	31114	CareSource of Ohio
128FL	Aetna Better Health of Florida	CAS89	CAS Coastal Administrative Services
26337	Aetna Better Health of Illinois	65391	CBHNP – Health Choice
128KS	Aetna Better Health of Kansas	CHOC1	CHOC Health Alliance
128KY	Aetna Better Health of Kentucky	CCA01	Central California Alliance for Health (CCAH)
128LA	Aetna Better Health of Louisiana	38219	Claimchoice Administrators (formerly AmeraPlan)
128MD	Aetna Better Health of Maryland	85468	Clear Spring Health
128MI	Aetna Better Health of Michigan	77052	Coastal TPA (Coastal Administrative)
46320	Aetna Better Health of New Jersey	COACC	Colorado Access
128NY	Aetna Better Health of New York	35193	Community Health Alliance
50023	Aetna Better Health of Ohio	27905	Community Health Alliance (TN)
23228	Aetna Better Health of Pennsylvania	48145	Community Health Choice
66917	Aetna Better Health -Parkland (TX)	45321	Consumers Choice Health Plan
28692	Aetna Better Health of Texas / TX Medicaid & CHIP	78375	Connecticare Medicare
128VA	Aetna Better Health of Virginia	47165	Core Benefits
128WV	Aetna Better Health of West Virginia	35182	CoreSource (AZ/IA/IL/IN/MD/MN/PA)
13334	Affinity Health Plan	48117	CoreSource KC (FMH)
ALTAM	AltaMed	35187	CoreSource Internal
20029	America's Choice Healthplan	35183	CoreSource (OH)
26119	American Insurance Administrators	75136	CoreSource Little Rock
44444	American Postal Workers Union (APWU)	58102	Covenant Administrators
77013	AmeriHealth Caritas	39081	Custom Benefit Administrators
45408	AmeriHealth Caritas Next Florida	82056	Custom Design Benefits
64090	Amfirst insurance	MCS03	Delano Regional Medical Group (MCS)
84323	Banner Medicare Advantage Plus PPO	37253	ELMCO (PHX)
84324	Banner Medicare Advantage Prime HMO	37216	Employee Benefit Services
66901	Banner University Care LTC	37215	Employee Benefits Corporation
88030	Baylor Scott and White Health Care Plan	45319	Evergreen Health
39081	Benefit Plan Administrators (WI)	59313	Evolution Healthcare
18768	Boulder Administration Services	94998	Firstcare (also enroll 94999)
68011	Capitol Administrators	94999	Firstcare Medicaid (also enroll 94998)
CARMO	Carelon Health – Palliative Care	25169	Gateway Health Plan - (Medicaid PA)
GACS1	CareSource of Georgia	60550	Gateway Health Plan - Medicare Assured
KYCS1	Caresource of Kentucky	MCS03	GemCare Medical Group (MCS)
INCS1	CareSource of Indiana	25531	Group Health, Inc. HMO (Emblem)
INCS1	CareSource Marketplace	13551	Group Health. Inc. PPO (Emblem)

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Payer ID	Payer Name	Payer ID	Payer Name
47083	Group Management Services (GMS)	41124	Meritain Health
64246	Guardian Life	MCC02	Molina Complete Care Virginia
62111	Health Cost Solutions	38333	Molina Healthcare
80142	Health Partners Plans (PA)	MLNNE	Molina Healthcare of Nebraska
HMA01	Healthcare Management Administrators	20149	Molina Healthcare of Ohio
71063	HealthSCOPE Benefits	SX109	Molina Healthcare of Utah
		37256	Mutual Assurance Administrators
37272	HealthSmart Benefit Solutions (JSL)	77076	Network Health Insurance (NHIC)
37283	HealthSmart Benefit Solutions (AA/GB)	81264	Nippon Life Benefits
87815	HealthSmart Benefit Solutions (WF/AN)	88027	Northern Nevada Trust Fund (BPA)
55247	HIP Health Plan of NY	22321	One Call Medical
00257	Highmark Health	04218	Pan American Life Insurance
47181	Highmark Health Options	SLOS1	Physicians Choice Medical Group of San Luis Obispo
74431	InHealth (Ohio PPO Connect)	MCI01	Physicians Choice Medical Group of Santa Maria
IMSMS	Insurance Management Services	55768	Piedmont Community Health Plan
51020	Integra Administrative Group	37224	Pittman & Associates (HealthSmart Benefit)
RP075	Iowa Health Advantage	CB404	Preferred Health Plan of the Carolinas
52189	John Hopkins Healthcare	35174	QualChoice of Arkansas
IP085	Kaweah Delta HC District Emp Plan	HMA01	Regence Group Administrators (RGA)
IP084	Kaweah Delta Medicare Advantage	37278	ResourceOne
KELSE	Kelsey Seybold	74205	Right Care from Scott & White
IP082	Key Medical Group	50114	Sana Benefits
IP083	Key Medical Group - Medicare Advantage	72261	SCAN Health Plan
42344	Keystone First Community Health Choices	23285	Select Health of South Carolina
23284	Keystone Mercy Health Plan	87020	Sentinel Security Life Insurance Company
LSMA2	LaSalle Medical Associates	SIM02	SIMPRA Advantage
LCB01	Line Constructions Benefit Fund	83245	Southwestern Health Resources
01260	Magellan Behavioral Health	25463	Surest (previously Bind)
MCS03	Managed Care Systems (MCS)	TKFMC	TKFMC
20805	Marrick Medical Finance	42137	TriStar
60230	Masonry Welfare Trust Fund	91078	Trusted Plans Service Corporation
04293	Mass General Brigham Health Plan	61425	Trustmark Insurance Company / Starmark
25160	MCA Administrators	74227	UHC Student Resources
39190	MedStar Family Choice	52180	UMWA Health & Retirement Funds
RP062	MedStar Family Choice DC	89070	United Concordia
RP063	MedStar Family Choice MD	TH023	WellMed Medical Management Inc.
22823	Med-American Benefits	93050	William C. Earhart Company
33628	Mercy Maricopa Integrated Care/Mercy Care RBHA	62111	W.C Beeler & Company

**EFT (Electronic Funds Transfer) and
ERA (Electronic Remittance Advice) Enrollment Form**

INSTRUCTIONS

- » This is a fillable form. Type your information into the form on your screen, or print the form and fill in the information.
- » Complete all sections that apply to your enrollment choice (EFT, ERA, or both EFT and ERA).
- » Enrollments are handled at the TAX ID level. All NPIs associated with the specified TIN will be automatically enrolled.
- » If your TAX ID would like to receive payments via more than one bank account, please contact EDI@EchoHealthinc.com.
- » Be sure to sign the form. Postal mail or email the completed form (secure email recommended). Postal mail: ECHO Health, Inc., 810 Sharon Drive, Westlake, Ohio 44145. Email: EDI@EchoHealthinc.com.
- » For information about the status of your enrollment, or for any other questions, please contact ECHO at 440.835.3511 or EDI@EchoHealthinc.com.

You will need to contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation.

Payer / Insurance Company Name: _____
(Please specify only one Payer per form)

For security purposes, please supply an ECHO Draft Number and matching Draft Amount to validate against your Tax ID. The Draft Number will be a 9-digit payment number beginning with a 1 or a 9. **NOTE: For ERA only, Draft Number and Draft Amount are *not required*.**

ECHO Draft Number _____ **ECHO Draft Amount \$** _____

1-Form Select (Required)

EFT & ERA **EFT Only** **ERA Only**

2-Provider Information (Required)

Provider Name: _____
(Complete legal name of institution, corporate entity, practice or individual provider)

Street: _____
(The number and street name where a person or organization can be found)

City: _____ **State/ Province:** **ZIP Code/Postal Code:** _____
(City associated with provider address field) *(ISO-3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.)* *(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.)*

3-Provider Identifiers Information (Required)

Provider Identifiers

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): _____
(A Federal Tax Identification Number, also known as an Employer Identification Number [EIN], is used to identify a business entity)

Does provider have a National Provider Identifier (NPI) Number? **Yes** **No**

If "Yes," enter NPI. 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 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.)

4-Provider Contact Information (Required for **EFT Only** or for **EFT & ERA** "Form Select" choice)

Provider Contact Name:
(Name of contact in provider office for handling EFT issues)

Telephone Number: **E-mail Address:**
(Associated with contact person) (An electronic mail address at which the health plan might contact the provider)

4A-Provider Contact Information (Required for **ERA Only** or for **EFT & ERA** "Form Select" choice)

Provider Contact Name:
(Name of contact in provider office for handling ERA issues)

Telephone Number: **E-mail Address:**
(Associated with contact person) (An electronic mail address at which the health plan might contact the provider)

5-Provider Agent Information (If Applicable and you selected **EFT Only** or **EFT & ERA** "Form Select" choice)

Provider Agent Name:
(Name of provider's authorized agent)

Provider Agent Contact Name:
(Name of contact in agent office for handling EFT issues)

Telephone Number: **E-mail Address:**
(Associated with contact person) (An electronic mail address at which the health plan might contact the provider)

5A-Provider Agent Information (If Applicable and you selected **ERA Only** or **EFT & ERA** "Form Select" choice)

Provider Agent Name:
(Name of provider's authorized agent)

Provider Agent Contact Name:
(Name of contact in agent office for handling ERA issues)

Telephone Number: **E-mail Address:**
(Associated with contact person) (An electronic mail address at which the health plan might contact the provider agent)

6-Financial Institution Information (Required for **EFT Only** or for **EFT & ERA** "Form Select" choice)

Financial Institution Name:
(Official name of the provider's financial institution)

Financial Institution Routing Number:
(A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited)

Type of Account at Financial Institution:
(The type of account the provider will use to receive EFT payment, e.g., Checking, Saving)

Provider's Account Number with Financial Institution:
(Provider's account number at the financial institution to which EFT payments are to be deposited)

Account Number Linkage to Provider Identifier. Select one option below.
(Provider preference for grouping [bulking] claim payments – must match preference for v5010 X12 835 advice)

Provider Tax Identification Number (TIN) **National Provider Identifier (NPI)**

7-Electronic Remittance Advice Information (Required for **ERA Only** or **EFT & ERA** "Form Select" choice)

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

(Provider preference for grouping [bulking] claim payment remittance advice – must match preference for EFT payment)

Does provider have a National Provider Identifier (NPI) Number? Yes No

Provider Tax Identification Number (TIN):
(Required if NPI is not applicable)

National Provider Identifier (NPI):
(Required if TIN is not applicable)

Method of Retrieval:
(The method in which the provider will receive the ERA from the health plan [e.g., download from health plan website, clearinghouse, etc.]

8-Electronic Remittance Advice Clearinghouse Information (Required for **ERA Only** or **EFT & ERA** "Form Select" choice)

Clearinghouse Name:
(Official name of provider's clearinghouse)

Clearinghouse Contact Name:
(Name of a contact in the clearinghouse office for handling ERA issues)

Clearinghouse Telephone Number:
(Telephone number of contact)

Clearinghouse E-mail Address:
(An electronic mail address at which the health plan might contact the provider's clearinghouse)

9-Electronic Remittance Advice Vendor Information (Required for **ERA Only** or **EFT & ERA** "Form Select" choice)

Vendor Name:
(Official name of provider's vendor)

Vendor Contact Name:
(Name of a contact in vendor office for handling ERA issues)

Vendor Telephone Number:
(Telephone number of contact)

Vendor Email Address:
(An electronic mail address at which the health plan might contact the provider's vendor)

10-Submission Information (Required)

Reason for Submission: New Enrollment Change Enrollment Cancel Enrollment

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)

Submission Date (YYYYMMDD):
(The date on which the enrollment is submitted)

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).

By signing below, provider acknowledges that the provider has read, agrees that it is subject to and agrees to comply with all terms and conditions, including those relating to the delivery of the services, which can be found at:
<https://view.echohealthinc.com/EFTERA/termandcondition.aspx>.

Signature of Person Submitting Enrollment: _____
(A [usually cursive] rendering of a name unique to a particular person used as confirmation of authorization and identity)

Postal mail or e-mail completed form (secure e-mail is recommended) to ECHO Health, Inc. If by email send to: EDI@EchoHealthinc.com.

CLEAR

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