



ERA LINKAGE FORM

Payer ID:

Payer Name:

PROVIDER INFORMATION

Provider Name:

Provider Tax ID:

Provider NPI:

Provider Contact Name:

Provider Contact Email:

Provider Contact Phone:

RECEIVER INFORMATION

OA Username:

Clearinghouse Name:

Effective Date:

Note: Effective Date may not be more than two weeks prior to the submission date of this form.

FORM SUBMISSION INSTRUCTIONS

For ERA Enrollment forms sent to Office Ally: Submit the ERA Linkage Form with the ERA Enrollment form.

For ERA Enrollment Forms NOT sent to Office Ally or for payers without ERA Enrollment: Submit the ERA Linkage Form to ERALinkage@OfficeAlly.com.