

Commercial ERA Payer	Enrollment Instructions – ERA
Payer Info	<p>This payer sends confirmation when ERA setup is approved. Yes <input checked="" type="checkbox"/> No Once ERAs begin coming in, this serves as confirmation of the 835 ERA setup.</p> <p>Note: This payer does not guarantee an ERA will be generated for all payments</p>
Checklist of Requirements	<p><input checked="" type="checkbox"/> The billing provider must have a Practice Insight EDI customer account number with billing provider Name, Tax ID and NPI.</p>
How and Where to Submit this Request	<p>SUBMIT To- Practice Insight</p> <p>LOG INTO EDInsight® GO TO [Search Tools] → [Enrollment] ADD or LOCATE, then SELECT payer enrollment record. CLICK [ATTACH File] to attach completed form to the record. CLICK [SUBMIT Enrollment to PI] to assign to Practice Insight for processing.</p>
Steps / Instructions for completing request.	<p>Availity Multi-Payer Electronic Remittance Advice Enrollment (1 page)</p> <p>[Provider Information] [Provider Contact Information] ENTER the billing provider's group information, including Provider's group Name, Address, Tax ID # and NPI #.</p> <p>[Electronic Remittance Advice Information] PUT <input checked="" type="checkbox"/> to SELECT ONLY ONE: __ Provider Tax ID (TIN) -or- __ Provider NPI # For the ONE selected, ENTER provider's group TIN # or group NPI # .</p> <p>[Submission Information] PUT <input checked="" type="checkbox"/> for New Enrollment or Change Enrollment</p> <p>[Authorized Signature] ENTER (type or sign) Signature of a person authorized to make this request. ENTER Printed Name of Person Submitting Enrollment ENTER Submission Date</p>
Estimated Time of Completion	
Contact Info to Follow Up or Make Inquiries	<p>Contact your EDI support vendor for assistance. Practice Insight Resellers or Support Vendors may contact Practice Insight Enrollment Department to check status of enrollment after 45 days. Please confirm this provider is currently submitting claims to this payer, and has received a payment from this payer within the last 14 days. You may be asked to provide recent payment information which includes, check date, check number and check amount.</p>



Multi-Payer Electronic Remittance Advice Enrollment

Rev. 03.04.2014.1

PAYER INFORMATION		Refer to the Availity Health Plan Partner List for payer IDs.	
Payer Name:		Payer ID:	
Payer Name:		Payer ID:	
Payer Name:		Payer ID:	
Payer Name:		Payer ID:	
Payer Name:		Payer ID:	
RECEIVER INFORMATION		* If different than provider contact information.	
Who will receive your ERA files?	Provider	Clearinghouse	Vendor
Receiver Name:		Availity Customer ID:	
Contact Name*:			
Telephone Number*:	Ext:	E-mail Address*:	
PROVIDER INFORMATION		PROVIDER IDENTIFIERS INFORMATION	
Provider Name:	Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):		
Street:			
City:	State/Province:	ZIP Code/Postal Code:	National Provider Identifier (NPI):
Provider Name:	Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):		
Street:			
City:	State/Province:	ZIP Code/Postal Code:	National Provider Identifier (NPI):
PROVIDER CONTACT INFORMATION			
Provider Contact Name:			
Telephone Number:		E-mail Address:	
ELECTRONIC REMITTANCE ADVICE INFORMATION			
Preference for Aggregation of Remittance Data	Provider Tax Identification Number (TIN):		
	National Provider Identifier (NPI):		
SUBMISSION INFORMATION			
Reason for Submission:	New Enrollment	Change Enrollment	Cancel Enrollment
Authorized Signature:			
<p>Important: By typing or signing a name in this field, you acknowledge and agree that you have been authorized by the provider or its agent to initiate, modify, or terminate an enrollment. You further acknowledge and agree that you have the legal authority to perform such action on behalf of your organization. In no event will Availity be liable for any losses or damages including without limitation, indirect or consequential losses or damages, or any loss or damage whatsoever arising from loss of data or profits arising out of, or in connection with this submission.</p>			
Printed Name of Person Submitting Enrollment:		Submission Date:	

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