Conifer Health Solutions
835

EDI Enrollment Instructions:

- The billing provider must have an EDIinsight customer account.
- SAVE this document to your computer. OPEN the file in Adobe Reader. TYPE directly on form pages.
- COMPLETE the form using the provider's billing/group information as credentialed with this payer.
- ONCE completed, ATTACH form to payer enrollment record within EDIinsight Enrollment Manager.
- SUBMIT enrollment request to EDIinsight Enrollment team, using EDIinsight Enrollment Manager.
- EDI enrollment processing timeframe is approximately 30 business days.
- Support Vendors may contact the payer at 818-461-5000 to request follow up on the request.

835 Electronic Remittance Advice:

Conifer Health Solutions EFT/ERA Authorization Agreement Form (2 pages)

Complete the **'Provider Contact Information'** section on Page 1.

If enrolling for EFT, complete the **'Electronic Funds Transfer'** section on Page 1. You must also include a voided check or bank letter with this agreement.

Check the box to indicate if this is a **'New Enrollment'** or **'Change Enrollment'** under the **'Submission Information'** section on Page 2.

Also, in this section, check the box to agree to the EFT Authorization **only** if enrolling for EFT.

Provider or Authorized Individual must print name, title, date, and sign under the **'Authorized Signature'** section on Page 2.

Submit Completed Documents to EDIinsight Enrollment:

LOGON to EDIinsight-Enrollment Manager
ADD or SELECT payer enrollment record.
CLICK [**ATTACH File**] to attach the document to the payer enrollment record. **Answer "Yes"** to Submit.
Or, click [**SUBMIT Enrollment**] to submit.

CONIFER
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Electronic Funds Transfer (EFT) / Electronic Remittance Advice (ERA) Authorization Agreement Form

PART I: PROVIDER AND IDENTIFIER INFORMATION

(1) Provider Name:

(2) Provider Federal Tax Identification Number (TIN):	(3) National Provider Identifier (NPI):

PART II: PROVIDER CONTACT INFORMATION

(4) Provider Contact Name:	(5) Title:

(6) Telephone Number:

(7) Email Address:

(8) Fax Number:

ELECTRONIC FUNDS TRANSFER SECTION:

(Skip to Part V- VII if enrolling in ERA only)

PART III: FINANCIAL INSTITUTION INFORMATION

(9) Financial Institution Name:

(10) Financial Institution Street Address:

(11) City:	(12) State: ☐	(13) Zip Code:
(14) Financial Institution Routing Number:	(15) Type of Account at Financial Institution:	☐ Checking ☐ Savings

(16) Provider's Account Number at Financial Institution:

(17) Account Number Linkage to Provider Identifier: *(Note: Must match ERA preference)*
Provider Tax Identification Number (TIN):

PART IV: SUBMISSION INFORMATION

(18) Reason for Submission:	☐ New Enrollment	☐ Change Enrollment	☐ Cancel Enrollment
(19) Include with Enrollment Submission: **Required for Processing (*EFT only*)**	☐ Voided Check	☐ Bank Letter (must be on the bank's letterhead)	

ELECTRONIC REMITTANCE ADVICE SECTION:

PART V: ELECTRONIC REMITTANCE ADVICE INFORMATION

(20) Preference for Aggregation of Remittance Data: *(Note: Must match EFT preference)*
Provider Tax Identification Number (TIN):

(21) Method of Retrieval

☐ Download from the Secured portal (Contracted Providers Only)

☑ Our Clearinghouse will retrieve all ERA files for us.
***Note**: Complete Clearinghouse Section below*

Your clearinghouse must have a relationship with our clearinghouse of choice: Availity

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PART VI: ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

(22) Clearinghouse Name: Availity LLC | (23) Clearinghouse Contact Name: AAC Enrollment

(24) Telephone Number: 800-282-4548

(25) Email Address: aacenrollment@availity.com

PART VII: SUBMISSION INFORMATION

(26) Reason for Submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Authorization (Applies to EFT only)

I hereby authorize clients of Conifer Value-Based Care to deposit, by electronic fund transfer, payments owed to the aforementioned provider and, if necessary, debit entries and adjustments for any amounts deposited in error. I recognize that if I fail to provide complete and accurate information on this Authorization Agreement the processing of the Agreement may be delayed or my payments may be erroneously transferred electronically. Conifer and its clients shall have no liability or responsibility for any payments erroneously transferred.

This Authorization Agreement is effective as of the signature date below and is to remain in full force and effect until Conifer has received written notification from the organization's authorized agent of a change or its termination in such time and such manner as to afford Conifer and the financial institution a reasonable opportunity to act on it. If the financial institution requires changes or if requesting termination of EFT, written notification must be submitted in the form of an updated Authorization Agreement.

I affirm all of the information contained in this enrollment application to be correct and true to the best of my knowledge. I understand providing false or misleading information on this enrollment application will result in rejection from the EFT payment program and that I will be responsible for any fees, legal or otherwise, incurred by Conifer or its clients on my behalf.

☐ I understand and agree to the EFT Authorization (Check Box) & enrollment will be applicable with any participating Conifer client

Authorized Signature (Applies to EFT and ERA)

(27) Written Signature of Person Submitting Enrollment:

(28) Printed Name of Person Submitting Enrollment:

(29) Printed Title of Person Submitting Enrollment:

(30) Submission Date: (31) Requesting EFT and/or ERA Start/Change/Cancel Date:

For Internal Use Only: Vendor # _____ **Company ID** _____
(Attach list of additional Vendor #/Facility # if applicable) Incident #: _____

EFT Set-Up Completed Date: _____ By: _____ EFT Effective Date: _____

ERA Set-Up Completed Date: _____ By: _____ ERA Effective Date: _____

Confirmation Sent To Provider on _____ By: _____ Method ☐ Fax ☐ E-mail