

## **Kaiser - Self Funded**

### **835**

#### **ERA Enrollment Instructions:**

- The billing provider must have an EDInsight customer account.
- SAVE this document to your computer.
- OPEN the file in the Adobe Reader program and type directly onto the form.
- COMPLETE the form using the provider's billing/group information as credentialed with the payer.
- PRINT, SIGN and SCAN or SAVE the signed form to your PC so that you may submit the form to the EDInsight Enrollment Team using EDInsight Enrollment Manager.
- Support Vendors may contact the EDInsight Enrollment Department for assistance.
- ERA enrollment timeframe is approximately 15 business days.

#### **835 Electronic Remittance Advice:**

##### **835 Electronic Remittance Advice (ERA) Enrollment Form (1 page)**

Ensure the Provider Contact fields are complete.

Provider or Authorized Person must sign where indicated on Page 1.

#### **Submit to EDInsight Enrollment Team:**

Within EDInsight - Enrollment Manager:

GO TO or **[ADD Payer Enrollment]** record for this payer.

SELECT record, CLICK **[ATTACH File]** to attach all pages of the completed payer form(s).

IF prompted, asking if you want to Submit the request, CLICK **[Yes]** -Or- CLICK **[SUBMIT Enrollment]**

ENTER any notes (optional)

CLICK to "**Save and Exit**" notes' window.



**835 ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT FORM**

**Please complete the following information:**

Activate Enrollment: Date: \_\_\_\_\_  Terminate Enrollment: Date: \_\_\_/\_\_\_/\_\_\_

Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Provider Contact: \_\_\_\_\_

Provider Phone Number: \_\_\_\_\_

Provider Tax Identification Number (TIN): \_\_\_\_\_

Provider National Provider Identifier (NPI): \_\_\_\_\_

Clearinghouse Name: Change Healthcare (CHC1)

Vendor Name: \_\_\_\_\_

This authority is to remain in full force and effect until Harrington Health has received written notification from me on its termination in such tome and such manner as to afford Harrington Health a reasonable time to act on notification.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Change Healthcare: Scan document and send via email to enrollment contact listed in Harrington Health documentation.

**Electronic Remittance Advise (ERA) – New Enrollment**