Payer ID: 01260

Magellan Behavioral Health
835

ERA Enrollment Instructions:

- The billing provider must have an EDIinsight customer record.
- 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 payer.
- PRINT and SCAN or SAVE the signed form to your PC so that you may submit the form to the EDIinsight Enrollment Team using EDIinsight Enrollment Manager.
- EDI enrollment processing timeframe is approximately 30 business days.
- **PLEASE NOTE:** There is a separate enrollment process for providers located in the following PA counties: Bucks, Cambria, Lehigh, Montgomery, Northampton. Complete the Magellan Healthcare ERA Registration Form on Page 2 if this applies to you.
- Other all providers will complete the Echo EFT and ERA Enrollment Form on Pages 3-5.
- This payer enrolls by Tax ID. Please only complete one form per Tax ID.
- To check status of EDI enrollment, EDIinsight Support Vendors can contact EDIinsight Enrollment.

835 Electronic Remittance Advice:

<u>(For Providers listed in PA counties above) Magellan Healthcare ERA Registration Form </u>(1 page)

Enter your MIS # under the Provider Information section.

Enter the ERA Effective Date under Set-Up Options.

Provider or Authorized Individual must sign where indicated at the bottom of Page 1.

<u>ECHO EFT and ERA Enrollment Form</u> (3 pages)

Complete the **'4A-Provider Contact Information'** section on Page 2.

Select your **'Reason for Submission'** under the **'10-Submission Information'** section on Page 3.

The Individual completing the agreement must enter their name, date, and sign at the bottom of Page 3.

Submit to EDIinsight Enrollment Team:

Within EDIinsight **-** Enrollment Manager:

SELECT record, CLICK **[ATTACH File]** to attach the completed payer form.

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

-Or- CLICK **[SUBMIT Enrollment]**

ENTER any notes (optional), then CLICK to **SAVE**.

Vendor = Waystar (formerly Claims Remedi)
TPID = CK

837 DIRECT SUBMIT AND 835 REGISTRATION OR TERMINATION FORM (ERA)

Electronic Remittance Advice (ERA) means receiving remittance data in an electronic form, such as the HIPAA X12.835.

This form must be completed by **individual provider applicants, provider groups, or organizations** that are requesting to submit an 837 file and receive an 835 remittance, in lieu of printed documentation. In order to be eligible, you must have a W-9 on file with Magellan* and be the owner of the Taxpayer Identification Number (TIN) under which claims are paid. This form is also used by providers to terminate the 837 and 835.

Fax the completed form to Attention: Network Data Management ERA Coordinator at 888-656-3259, or mail the completed form to:

Magellan Healthcare
14100 Magellan Plaza – MO14
Maryland Heights, MO 63043
Attn: Network Data Management ERA Coordinator

PROVIDER INFORMATION

PROVIDER NAME: ______________________________

ADDRESS LINE1: ______________________________

ADDRESS LINE2: ______________________________

CITY: ____________ **STATE:** ________ **ZIP CODE:** ________

TIN: ____________ **NPI #:** ____________ **MIS #:** ____________

Check Type: __ **Employer Identification Number (EIN)** __ **Social Security Number (SSN)** ✔ **I Tax Identification Number (ITIN)**

NOTE: Groups must enroll their group number only

PROVIDER AGENT CONTACT NAME: ______________________________

TELEPHONE#: ____________ **EMAIL ADDRESS:** ____________

SET-UP OPTIONS

☑ **SET UP** – Enroll the entire Tax ID. All providers who bill under the TIN enrolled will receive ERA.

ERA EFFECTIVE DATE: ____/____/____ *Cannot be earlier or more than 180 days from the date you sign this form.*

This authority shall remain in effect unless you submit a written cancellation notice to Magellan. Electronic transmissions of remittance advice will not occur until Magellan initiates a claim payment to you and a successful test is conducted between Magellan and your clearinghouse. The actual Effective Date (or Termination Date) will be assigned after this process occurs. Meanwhile, remittance advice will continue to be mailed to you.

☐ **STOP** Electronic Remittance Advice. I understand I will receive paper remittance advice when this request is processed.

ERA TERMINATION DATE: ____/____/____ *Cannot be earlier than the date you sign this form.*

AUTHORIZED SIGNATURE: ______________________________

The person(s) signing this form must be authorized to sign on behalf of the provider receiving claims remittances.

DATE: ______________________

*In California, Magellan does business as Human Affairs International of California, Inc. and/or Magellan Health Services of California, Inc. – Employer Services. Other Magellan entities include Magellan Healthcare, Inc. f/k/a Magellan Behavioral Health, Inc.; Merit Behavioral Care; Magellan Health Services of Arizona, Inc.; Magellan Behavioral Health of Florida, Inc.; Magellan Behavioral of Michigan, Inc.; Magellan Behavioral Health of Nebraska, Inc.; Magellan Behavioral Health of New Jersey, LLC; Magellan Behavioral Health of Pennsylvania, Inc.; Magellan Providers of Texas, Inc.; and their respective affiliates and subsidiaries; all of which are affiliates of Magellan Health, Inc. (collectively "Magellan"). National Imaging Associates, Inc. is a subsidiary of Magellan Healthcare, Inc.

ONLINE

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* submit the form via the ECHO secure portal. Postal mail: ECHO Health, Inc., 810 Sharon Drive, Westlake, Ohio 44147. Or, submit via secure portal: https://edi.echohealthinc.com/new-ticket.
- 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 delivery of CORE-required Minimum CCD+ Data Elements necessary for successful reassociation.

Payer / Insurance Company Name: MagellanHealth
(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 or 10-digit payment number beginning with a 1, 2 or a 3. 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:
(City associated with provider address field)

State/Province:
(ISO-3166-2 Two-character Code associated with the State/Province/Region of the applicable Country.)

Zip Code/Postal Code:
(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)*

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 number 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: Clearinghouse
(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: Practice Insight
(Official name of provider's clearinghouse)

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

Clearinghouse Telephone Number: 713-333-6000 Opt 2
(Telephone number of contact)

Clearinghouse E-mail Address: pi-enrollment@waystar.com
(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 contact in vendor office for handling ERA issues)

Vendor Telephone Number:
(Telephone number of contact)

Vendor E-mail 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 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 or paper-based manual enrollment.*

☑ By signing below, provider acknowledges that the provider has read, agrees that is it 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://enrollments.echohealthinc.com/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 submit form via the ECHO secure portal. See page 1 of this form for instructions.