Practice Insight®

Rev Date 09/21/2021
Rev Type NPF

Commercial ERA Payer	**FIRST MEDICAL (66053)** **Enrollment Instructions – ERA**
Payer Info	This payer sends confirmation when ERA setup is approved. **Yes** ✓ **No** Once ERAs begin coming in, this serves as confirmation of the 835 ERA setup. **Note: This payer does not guarantee an ERA will be generated for all payments.**
Checklist of Requirements	✓ The billing provider must have a Practice Insight EDI customer account number. ✓ Submission of electronic claims to this payer is required prior to ERA setup.
How and Where to Submit this Request	**Submit to EDIinsight Enrollment Team:** Within EDIinsight - 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.
Steps / Instructions for completing request.	**Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) Authorization Form (2 pages)** Select New or Change of EFT at the top of the form Complete this form by entering the Billing Provider's Group information to include, NPI, Tax ID, and provider address. Enter the financial information for EFT.
Estimated Time of Completion	**Allow 4 Weeks for ERA setup to be completed by the payer.**
Contact Info to Follow Up or Make Inquiries	The provider may follow up with the payer direct at fm-eftpayment@firstmedicalpr.com Practice Insight Resellers or Support Vendors may contact Practice Insight Enrollment Department to check on status of enrollment after 45 days. When contacting Practice Insight please make sure a copy of the payer form that was submitted is attached to enrollment record within EDIinsight Enrollment Manager.

First MEDICAL HEALTH PLAN, INC.

Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) Authorization Form

All fields must be completed. Forms with incomplete or invalid information cannot be processed.

Section I. Reason for Submission: Please select only one

☐ **New EFT Authorization-** Select the business line ☐ **Commercial** ☐ **GHP/Vital**

☐ **Request a Change**

☐ **EFT Cancellation-** Enclose a letter with a brief explanation of the cancellation reason.

Section II. Provider Information:

Provider Name:	**IMC Provider Number:** *If applicable*
Doing Business As (DBA) Name:	
Provider Mailing Address:	
Street:	**City:**
State:	**PO Box:** / **Zip Code:**
Provider Personal Contact Information:	
Telephone Number:	**Email Address:**
Provider Identifiers:	
Provider Federal Tax Identification Number (TIN):	**National Provider Identifier (NPI):**
Provider Contact Office Information:	
Provider Contact Name:	**Relation with the Provider:**
Telephone Number:	
Fax Number:	**Email Address:**
Clearinghouse Information:	
Assigned Authority: Practice Insight	**Trading Partner ID:** 161622439

Section III. Financial Institution Information:

Financial Institution Name:

Financial Institution Address:

Financial Institution Routing Number:			
Financial Institution Provider's Account Number:			
Financial Institution Provider's Account Type:	☐ **Checking Account**	☐ **Savings Account**	

Section IV. Authorization and Signature:

I hereby authorize First Medical Health Plan, Inc., to initiate entire credits and/or adjustments for any duplicate or erroneous credits made to previously mentioned account. I hereby authorize the Financial Institution previously mentioned to make any credits and/or debits made by First Medical Health Plan, Inc., of the previously mentioned account. I understand that this authorization form will be part of the Terms and Conditions Agreement and will be included signed as part of this authorization form. I certify that the previously mentioned account is drawn in the name of the physician or individual practitioner or the legal business name of the provider or supplier. I certify that I sole control of the previously mentioned account in which First Medical Health Plan, Inc., will made the EFT deposits and that this account complies with all applicable Federal and State Laws and Regulations.

Printed Name of the person that submitting the EFT and ERA Authorization Form:	
Printed Title of the person that submitting the EFT and ERA Authorization Form:	
Provider Signature:	**Submission Date:**

**********************DO NOT WRITE BELOW THIS LINE**********************

First Medical Health Plan, Inc., and International Medical Card, Inc., Internal Use

Receipt Date:	☐ ***Completed***	☐ ***Lack of Information***
Completion Date:	***Sending Notification Date:***	
Completed by:	***Sent by:***	

***** Please complete and signed this EFT and ERA Authorization Form and send it with the requested letters to First Medical Health Plan, Inc., at the address, fax or email provided in the Instructions to Complete and Send the EFT and ERA Authorization Form.**