



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms
05/31/2016 (IE)

HealthChoice Oklahoma - EDS Admin Services (22521) Non-Par Payer Enrollment Instructions –ERA ONLY

- ✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record(s) added.** Please contact your EDI support vendor to confirm your EDI customer account setup.

CHOOSE ONE METHOD- to submit to Practice Insight

- A. Enrollment Manager:** PI Support Vendors can submit request directly into Enrollment Manager Tool.
- B. Email:** enrollment@practiceinsight.net

835- ERAs Electronic Remittance NEW or CHANGE OF SERVICE

1. Practice Insight 835-ERA (1 page)

Complete this form using the billing provider group information.

2. HealthChoice Electronic Remittance Advice (ERA) Authorization Agreement (1 page)

Complete these forms using the billing provider group information. Authorized Signature Required.

3. Emdeon Change of Vendor Letter (1 page)

IMPORTANT: The letter must be printed on the provider/site's letterhead and contain all information listed in the template. Authorized Signature Required.

ALLOW 4-6 WEEKS FOR PROCESSING

If you do not begin receiving ERAs within 45 days after the request has been submitted, contact your support vendor for assistance. Practice Insight Resellers or Support Vendors may contact Practice Insight Enrollment Department direct to check on status of enrollment.



Send completed forms to Practice Insight
 Email: enrollment@practiceinsight.net

835-ERA Provider Enrollment Form

Payer Information		
Payer Name:		Payer ID#:
		Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier) Select One: Tax Identification Number (TIN):
New Request:	Change Request:	National Provider Identifier (NPI):
Provider Information		
Billing Provider Name:		
Billing NPI:		Tax ID:
Telephone Number:		Fax Number:
Primary Address:		
City:	State:	Zip:
Billing Address (if diff from primary):		
City:	State:	Zip:
Contact Information		
Contact Name:		
Telephone Number:		Email:
EDI Information		
Support Vendor / Reseller:		EDI Cust #:
Receiver Name:	Practice Insight	

Please Allow 4-6 Weeks For Processing



Oklahoma Department
Of Rehabilitation Services



Electronic Remittance Advice (ERA) Authorization Agreement

Provider Information

Provider Name: _____

Doing Business As Name (DBA): _____

Provider Address

Street: _____

City: _____ State/Province: _____ ZIP Code/Postal Code: _____

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or
Employer Identification Number (EIN): _____

National Provider Identifier (NPI) _____ Provider Type: _____

Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier)

Provider Tax Identification Number (TIN): _____

National Provider Identifier (NPI): _____

Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name: EMDEON

Clearinghouse Contact Name: ENROLLMENT HELP DESK Telephone Number: 866-924-4634

Submission Information

Reason for Submission

New Enrollment

Change Enrollment

Cancel Enrollment

Authorized Signature

I hereby authorize the Office of Management and Enterprise Services (OMES) Employees Group Insurance Division (EGID) to send electronic remittance advice (ERA/835) as designated herein. I am authorized to elect Electronic Remittance Advice (ERA) transactions on behalf of the indicated party and I acknowledge the same by signing below.

Written Signature of Person Submitting Enrollment: _____

Printed Name of Person Submitting Enrollment: _____

Printed Title of Person Submitting Enrollment: _____

Submission Date: _____

Please mail, fax or email the completed form or questions to:
Employees Group Insurance Division (EGID), Office of Management and Enterprise Services (OMES)
3545 NW 58th St, Ste 110, Oklahoma City, OK 73112
Phone: 1-405-717-8790 or 1-800-543-6044 or Fax: 1-405-717-8977 or 1-405-717-8702
EGID.EFTEnroll@omes.ok.gov or EGID.NetworkManagement@omes.ok.gov

Emdeon Enrollment Department
Attn: Enrollment Department – Merge Group ERA Set Up
batchenrollment@emdeon.com
Fax: 615.885.3713

Dear Emdeon

Currently, I am receiving my Electronic Remittance Advice through

I would like to start receiving my Electronic Remittance Advice through Emdeon Corporation using

This change request will also include ALL PROVIDERS associated with this tax ID.

Please carry over all payers associated with the below tax id with merge group.

Please move only the payers listed on the attached ERA PSF with merge group.

Please accept this letter as my request to change vendors. Following is specific information regarding my practice:

Name:

Practice:

Address:

Phone #:

Contact:

Email:

Tax Id:

Sincerely,

Printed Name

Title