
Health Net of California and Oregon 835

EDI 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 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.
- ERA enrollment processing timeframe is approximately 30 days.
- Support Vendors may contact the EDInsight Enrollment Team to follow up on the ERA setup request.

835 Electronic Remittance Advice:

Complete and submit this form using the billing provider's group information.

1. Health Net of California Electronic Remittance Advice (ERA) Authorization Agreement

VERIFY/ENTER provider's group information.

UNDER "Submission Information"

PUT Check for NEW or CHANGE

OBTAIN "Authorized Signature" ENTER "Printed Signature of Person Submitting Enrollment"

ENTER "Submission Date" ENTER "Requested ERA Effective Date"

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.

Health Net of California Electronic Remittance Advice (ERA) Authorization Agreement

Provider Information

Provider Name _____
 Provider Address Street _____
 City _____ State _____ Zip _____

Provider Identifiers Information

Provider Identifiers
 Provider Federal Tax Identification Number (TIN) _____ National Provider Identifier (NPI) _____
 or Employer Identification Number (EIN) _____

Provider Contact Information

Provider Contact Name _____ Telephone Number _____
 Email Address _____ Fax Number _____

Provider Agent Information

Provider Agent Name _____
 Telephone Number _____ Email Address _____

Electronic Remittance Advice Information

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

Provider Tax Identification Number (EIN) _____ National Provider Identification Number (NPI) _____

Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name _____
 Telephone Number _____ Email Address _____

Electronic Remittance Advice Vendor Information

Vendor Name _____
 Telephone Number _____ Email Address _____

Submission Information

Reason for Submission: New Enrollment Change Enrollment Cancel Enrollment

Authorized Signature:

Printed Signature of Person Submitting Enrollment _____
 Submission Date _____ Requested ERA Effective Date _____

This authorization is to remain in effect until written notice in the form of an ERA Authorization Agreement form marked as a cancellation or change form is submitted to Health Net. Any changes to the providers agent, clearinghouse or vendor must be submitted on an ERA Authorization Agreement form as a change. The termination or change shall be effective 20 days subsequent to Health Net's receipt of the updated form.