
Health New England 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 20 days.
- Support Vendors may contact the EDInsight Enrollment Team to follow up on the ERA setup request. Please confirm this provider is currently submitting claims to this payer and has received a payment from this payer within the last 14 days. You may be asked to provide recent payment information which includes, check date, check number, and check amount.

835 Electronic Remittance Advice:

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

Health New England 835 Healthcare ERA Request & Compensation EFT Enrollment Form (2 pages)

On Page 1, under 'Select an Enrollment Type,' check the box next to 'New Enrollment' or 'Change Enrollment.'

On Page 1, Section A, check the box next to the applicable Provider type and complete the Provider Contact Information fields.

On Page 2, Section G, the Individual completing the agreement needs to print title, name, date, phone number, email, and sign where indicated.

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.

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 HEALTHCARE ELECTRONIC REMITTANCE
 ADVICE (ERA) REQUEST & COMPENSATION
 ELECTRONIC FUNDS TRANSFER (EFT) ENROLLMENT FORM**

Fax: 413.233.2665 or Email: penrollment@hne.com

If you would like to submit this form through our website, please click link to go to: <https://www.hnedirect.com/ef/EFTPage1.aspx>.
 *Indicates required fields within each section. Incomplete and/or illegible fields may cause your enrollment to be delayed.

SELECT AN ENROLLMENT TYPE	ERA ONLY	EFT ONLY	BOTH ERA & EFT
NEW ENROLLMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHANGE TO ENROLLMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCEL ENROLLMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION A - PROVIDER/GROUP/FACILITY INFORMATION

PLEASE SELECT THE OPTION(S) THAT APPLY
 INDIVIDUAL PROVIDER GROUP/PRACTICE FACILITY BOTH GROUP & FACILITY

*PROVIDER/GROUP/FACILITY NAME

*PROVIDER TAX ID (MULTIPLE TAX IDs SEE ATTACHMENT 1) (TAX FIELDS MUST CONTAIN 9 DIGITS) PROVIDER NPI (NPI FIELDS MUST CONTAIN 10 DIGITS)

*PROVIDER CONTACT NAME *PROVIDER CONTACT PHONE NUMBER *PROVIDER CONTACT EMAIL

*PROVIDER BILLING ADDRESS *CITY *STATE *ZIP

SECTION B - VENDOR INFORMATION/CLEARINGHOUSE/BILLING AGENT (IF YOU ARE USING A VENDOR THE FOLLOWING INFORMATION IS REQUIRED. CLICK [HERE](#) TO SEE LIST OF VENDORS.)

VENDOR NAME **CHC1** VENDOR TAX ID **581651222**

VENDOR CONTACT PHONE NUMBER **800-527-8133, option 1** BY CHECKING HERE, PROVIDER AUTHORIZES HEALTH NEW ENGLAND, INC. TO TRANSMIT PROVIDER'S 835 FILES TO VENDOR.

PROVIDER, Smith, John A MD, HEREBY APPOINTS CHC1
PROVIDER NAME/PROVIDER REPRESENTATIVE NAME (PLEASE PRINT) VENDOR NAME (PLEASE PRINT)
 TO ACT AS THE AUTHORIZED AGENT FOR THE PURPOSE OF RETRIEVING THE 835 ERA ELECTRONICALLY FROM HEALTH NEW ENGLAND, INC.

SECTION C - ERA ACKNOWLEDGMENT

Providers who choose to receive 835 transactions directly from HNE may elect to return a 999 Acknowledgement file. HNE does not require this but if you do opt in, you must always transmit the acknowledgement file.

Please check here if you will be sending an 999 Acknowledgement file.

SECTION D - PROVIDER CERTIFICATION

THE UNDERSIGNED PROVIDER, _____,
PROVIDER NAME (PLEASE PRINT)

HEREBY CERTIFIES TO HEALTH NEW ENGLAND, INC. THE FOLLOWING WITH RESPECT TO THE 835 ELECTRONIC REMITTANCE ADVICE:

- Provider will coordinate receipt of remittance test file(s) from the designated clearinghouse/vendor if a vendor is named.
- Provider acknowledges that it will complete the test file(s) and use the 835 ERA data for posting to their accounting systems.
- Provider will notify their EDI Vendor of their intention to begin ERA testing.
- Provider agrees that upon approval of this Certification and the initiation of routine ERA processing, Provider will no longer receive a hard copy EOR (Explanation of Remittance) after thirty (30) days from production.
- Provider, or an authorized representative of Provider, will notify Health New England, Inc. in writing of any changes or corrections required in the ERA process.

SECTION E - EFT/FINANCIAL INSTITUTION

New EFT enrollments or changes to existing EFT banking information will take **up to** fifteen business days to complete.
 New ERA enrollments or changes to existing ERA information will take **up to** thirty-five business days to complete.

*FINANCIAL INSTITUTION/BANK NAME

*NAME AS IT APPEARS ON BANK ACCOUNT

*BANK ADDRESS

*CITY

*STATE

*ZIP

*TYPE OF BANK ACCOUNT

CHECKING SAVINGS

*BANK ROUTING NUMBER

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*BANK ACCOUNT NUMBER

SECTION F - CHANGE/CANCEL ENROLLMENT IF YOU ARE REQUESTING AN EFT CHANGE (YOUR BANK AND/OR BANK ACCOUNT NUMBER), THE FOLLOWING INFORMATION IS REQUIRED:

*PREVIOUS BANK NAME

*PREVIOUS BANK ADDRESS

*CITY

*STATE

*ZIP

*TYPE OF BANK ACCOUNT

CHECKING SAVINGS

*PREVIOUS BANK ROUTING NUMBER

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*PREVIOUS BANK ACCOUNT NUMBER

SECTION G - PROVIDER AUTHORIZATION/SIGNATURE

The undersigned Provider hereby authorizes and requests Health New England, Inc. (HNE) to effect payment for all amounts owed to the Provider by HNE as such amounts become payable. Payment shall be made by initiating entries to the Provider's account in the bank or financial institution indicated above. The Provider authorizes and requests said bank or financial institution to credit the same to such account.

This authorization is active as of two weeks after HNE receives the request and shall remain in effect until terminated. The Provider may terminate this authorization without cause by giving 15 days prior written notice to HNE. HNE may terminate this authorization without cause at any time.

I agree that if unearned or erroneous payment is credited to my account by HNE, I will immediately repay HNE the full amount of such unearned or erroneous pay. I also agree to allow an automatic reversal of any deposits made in error.

AUTHORIZED REPRESENTATIVE SIGNATURE

(X)

PRINT TITLE

PRINTED NAME OF AUTHORIZED REPRESENTATIVE

DATE

AUTHORIZED REPRESENTATIVE PHONE NUMBER

AUTHORIZED REPRESENTATIVE EMAIL

ATTACHMENT 1 - MULTIPLE TAX IDs

Please complete this section only if you need to list additional Tax IDs that are in addition to the one listed in Section A.

FACILITY/GROUP/PRACTICE/PROVIDER NAME	TAX ID (TAX FIELDS MUST CONTAIN 9 DIGITS)	NPI (NPI FIELDS MUST CONTAIN 10 DIGITS)	BILLING ADDRESS