eSolutions
Strengthen your revenue health
EDI Insight

Payer IDs: MMFMC, GNPMG

Bristol Park Medical Group & MemorialCare Medical Foundation
Edinger Medical Group & Greater Newport Physicians
835

EDI Enrollment Instructions:

- The billing provider must have an EDIinsight 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 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.
- ERA enrollment processing timeframe is approximately 15 days.
- Support Vendors may contact the EDIinsight Enrollment Team to follow up on the ERA setup request. Or email the payer at MCMF.EDISupport@memorialcare.org and ask if you have been setup for ERAs via Office Ally.

835 Electronic Remittance Advice:

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

1. **MemorialCare Health System Electronic Remittance Advice (835) Enrollment Request Form (1 page)**
   Complete the 'Provider Contact Information' section.
   Choose your 'Reason for Submission' under the 'Submission Information' section.
   Provider or Authorized Individual must sign under the 'Signature' section.
2. **Office Ally ERA Linkage Form (1 page)**
   Enter the Payer ID and Name of the payer you are enrolling for.
   Complete the Provider Contact Information fields under the 'Provider Information' section.
   Enter the Effective Date for the enrollment under the 'Receiver Information' section.

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.
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.

Electronic Remittance Advice (835)
Enrollment Request

MEMORIALCARE®
HEALTH SYSTEM
Excellence in Health Care

INSTRUCTION

Please make sure to complete this form in its entirety. **All information entered on this form should be the same information shown on your W-9 or Income Tax.** Incomplete information will result in a delay with your request. Please email the completed form to MCMF.EDISupport@memorialcare.org.

PROVIDER INFORMATION

Provider Name:

Address:

City: **State:** **Zip Code:**

PROVIDER IDENTIFIER INFORMATION

Provider Federal Tax Identification Number
Employer Identification Number (EIN):

National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION

Contact Name:

Phone Number: **Email:**

SUBMISSION INFORMATION

Reason for Submission: Clearinghouse: Office Ally

Comment:

SIGNATURE

Authorized Signature:

Note: Electronic Signature (Typed Name) of Person Submitting ERA Enrollment Form.

ERA LINKAGE FORM

Payer ID:

Payer Name:

PROVIDER INFORMATION

Provider Name:

Provider Tax ID:

Provider NPI:

Provider Contact Name:

Provider Contact Email:

Provider Contact Phone:

RECEIVER INFORMATION

OA Username:

Clearinghouse Name:

Effective Date:

Note: Effective Date may not be more than two weeks prior to the submission date of this form.

FORM SUBMISSION INSTRUCTIONS

For ERA Enrollment forms sent to Office Ally: Submit the ERA Linkage Form with the ERA Enrollment form.

For ERA Enrollment Forms NOT sent to Office Ally or for payers without ERA Enrollment: Submit the ERA Linkage Form to **ERALinkage@OfficeAlly.com**.