

Metro Plus Health Plan ERA Request

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 forms using the provider's billing/group information as credentialed with this payer.
- If changing ERA clearinghouse, the provider must send an email to the payer as follows:

To: mhpeditinquiry@metroplus.org

Subject: Request to Change ERA Clearinghouse for Provider

Billing Provider Name,

NPI #

Tax ID #

In the body: "Please accept this request to change this provider's clearinghouse for delivery of MetroPlus ERAs to the clearinghouse Change Healthcare."

(NOTE: Do NOT indicate Waystar or Practice Insight as the Clearinghouse. The clearinghouse name must be Change Healthcare, as they are the intermediary for delivery of this payer's ERAS).

- EDI enrollment processing timeframe is approximately 25 business days.

835 Electronic Remittance Advice:

1. Change Healthcare Remittance Form (1 page).
Verify provider's data on the form and add any missing information such as Contact Name, etc.
2. MetroPlus Health Plan ERA Provider Setup Form (1 page)
Verify provider group's data and add any missing information such as the Contact Name, etc.
Under Additional Associated Practices/Facilities
Add NPIs if there are additional Practices/Facilities with group NPI #s.

Submit Completed Documents within EDInsight - Enrollment Manager:

LOGON to EDInsight-Enrollment Manager

ADD or SELECT payer enrollment record.

CLICK [**ATTACH File**] to attach the document to the payer enrollment record. **Answer "Yes"** to Submit.

Or, click [**SUBMIT Enrollment**] to submit.

Payer Information					
CPID	Payer ID	Payer	Type	Est Days	Multi CH
Special Enrollment Instructions					
Vendor Information					
Submitter ID	Submitter Name				
Provider Information					
Tax ID	NPI	Provider Number	Name		
Address			City	State	Zip
Contact Name				Contact Phone	
Contact Email Address					
Confirmation Addresses					
Primary Email Address			Secondary Email Address		
ERA Receiver					
Distribution Detail					



ERA Provider Setup Form

(Payer ID 13265)

Provider Organization

Practice/Facility Name					
Practice/Facility Address					
	City		State		Zip Code
Contact Name			Contact Phone		
Contact Email					
Tax ID			Billing NPI ID		

* All fields are required

Additional Associated Practices/Facilities

* All NPI IDs associated with a provider organization are required for full ERA enrollment. Attach a separate list if necessary.

Practice/Facility Name		NPI ID	
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Practice/Facility Name		NPI ID	
Practice/Facility Name		NPI ID	
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Submit completed form to Relay Health