PrimeCare Medical Network
NAMM North American Medical Management
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 30 days.
- Support Vendors may contact the EDIinsight Enrollment Team to follow up on the ERA setup request. Or contact the payer at EDIOperations@nammcal.com.

835 Electronic Remittance Advice:

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

1. **Optum Electronic Remittance Advice (ERA) Enrollment Form (1 page)**
   Complete the 'Provider Contact Information' section.
   Check your 'Preference for Aggregation of Remittance Data' and 'Reason for Submission.'
   Provider or Authorized Individual must print name, date and sign where indicated.
2. **Office Ally ERA Linkage Form (1 page)**
   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 (ERA) Enrollment Form

Return Completed Forms to:
Email:
EDIOperations@nammcal.com
Fax: (866) 596-7210
Mail: EDI Department
3990 Concours, Suite 500
Ontario, CA. 91764

Please PRINT clearly
Please note: Upon enrollment processing, Provider will receive both Paper Explanation of Payment and Electronic Remittance Advice (ERA) for 31 calendar days, after which time Provider will **only** receive ERA.

Provider Information (REQUIRED)

Provider Name:		
Provider Address Street:		
City:	State/Province:	Zip Code/Postal Code:

Provider Identifiers (REQUIRED)

Provider Federal Tax Identification Number (TIN) or Employer Identification Number:	
National Provider Identifier (NPI):	

Provider Contact Information

Provider Contact Name:		Title:
Telephone Number:	Telephone Number Extension:	Email Address:

Electronic Remittance Advice Information (REQUIRED)

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

☐ Provider Tax Identification Number (TIN) ☐ National Provider Identifier (NPI)

Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name:
Office Ally

Submission Information

Reason for Submission: ☐ NEW Enrollment ☐ CHANGE Enrollment ☐ CANCEL Enrollment

The undersigned hereby certifies that the information provided herein is true and accurate in all respects and that he/she has been duly authorized by all necessary and appropriate corporation action, where applicable, to execute this agreement on behalf of the above mentioned Provider Name to form a legally binding contract. The undersigned authorizes Optum, PrimeCare Medical Network, Inc. (PMNI) and their affiliates (collectively referred to as "OPTUM") to transmit electronic remittance advice (ERA) detail for claims processed by OPTUM to the provider listed above. In addition, the undersigned hereby agrees that upon completion of enrollment processing, OPTUM will concurrently send paper explanation of payment and ERA for a period of 31 calendar days, after which time provider will only receive ERA.
This Authorization is to remain in full force and effect until OPTUM has received written notification of its termination in such time and manner as to afford OPTUM a reasonable opportunity to act on it.

Authorized Signature:_____ Date:_____

Printed Name of Person Submitting Enrollment

Updated: August 2024

Office Ally

ERA LINKAGE FORM

PROVIDER INFORMATION

Provider Name:

Provider Tax ID:

Provider NPI:

Provider Contact Name:

Provider Contact Email:

Provider Contact Phone:

RECEIVER INFORMATION

OA Username: pinsight

Clearinghouse Name: Practice Insight

Effective Date:

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

PAYER INFORMATION

ERA Linkage will be applied to **all payers** based on the **Provider's NPI, Tax ID** and Receiver information.

FORM SUBMISSION INSTRUCTIONS

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