Neighborhood Health Plan - MA (04293)

Enrollment Instructions –ERA ONLY

✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record(s) added.** Please contact your EDI support vendor to confirm your EDI customer account setup.

CHOOSE ONE METHOD to submit to Practice Insight

A. **Enrollment Manager:** PI Support Vendors can submit request using this tool.

B. **Email:** enrollment@practiceinsight.net

ERAs (835) NEW or CHANGE OF SERVICE

Neighborhood Health Plan of MA Electronic Remittance Advice Authorization Agreement (1 pg)

Complete this form using the billing provider’s group information.
Ok to skip “Assigning Authority” and “Trading Partner ID” (these fields not required).
See bottom of form—Signature required.

ALLOW 4-6 WEEKS FOR PROCESSING

If you do not begin receiving ERAs within 45 days after the request has been submitted, contact your support vendor for assistance. Practice Insight Resellers or Support Vendors may contact Practice Insight Enrollment Department direct to check on status of enrollment.

Electronic Remittance Advice Authorization Agreement

Fields marked * are required

Provider Information

*Provider Name: ____________________

*Provider Street Address: ____________________

*City: ____________________ *State/Province: ____________ *Zip Code/Postal Code: ____________

Provider Federal Tax ID Number (TIN) or Employer Identification Number (EIN): ____________________

*National Provider Identifier (NPI): ____________________

Assigning Authority: ____________________

Trading Partner ID: ____________________

Provider Contact Information

*Provider Contact Name: ____________________

*Telephone Number: ____________________ Fax Number: ____________________

Email Address: ____________________

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

- Provider Tax Identification Number (TIN)
- ○ National Provider Identification Number (NPI)

Method of Retrieval:

- ○ Direct Retrieval
- ○ Clearinghouse
- ○ Billing Service

ERA Clearinghouse Information

Clearinghouse Name: ____________________

Telephone Number: ____________________ Email: ____________________

Reason for Submission:

- ○ New Enrollment
- ○ Change Enrollment
- ○ Cancel Enrollment

Authorized Signature

Signature of Submitter: ____________________

Printed Title of Person Submitting Enrollment: ____________________

Submission Date: ____________________ Requested ERA Effective Date: ____________________