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## Healthy Medical Group 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 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 15 days.
- Support Vendors may contact the EDInsight Enrollment Team to follow up on the ERA setup request.

### 835 Electronic Remittance Advice:

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

**1. Office Ally 835- Enrollment Information Form (1 page)**

Complete the 'Provider Contact Information' section.

Provider or Authorized Individual must print name, title, and sign at the bottom of the page.

**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 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-ENROLLMENT INFORMATION FORM

### PROVIDER INFORMATION

Provider Name:

Provider Address:

### PROVIDER IDENTIFIER INFORMATION

Tax Identifier (TIN or EIN):

National Provider Identifier (NPI):

### PROVIDER CONTACT INFORMATION

Provider Contact Name:

Telephone Number:

Email Address:

### PAYER NAME

Name of Payer Enrolling:

### SUBMISSION INFORMATION

Authorized Signer Name & Title:

Authorized Signature:

**NOTE:** *Electronic Signature (typed name) of person submitting ERA Enrollment*



# 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:

Clearinghouse Name:

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](mailto:ERALinkage@OfficeAlly.com).