

## MemorialCare Select Health Plan 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 30 days.
- Support vendors may contact the EDInsight Enrollment Team to follow-up on ERA request.
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### 835 Electronic Remittance Advice:

Complete and submit these forms using the billing provider's information.

#### 1. MemorialCare Electronic Remittance Advice (835) Enrollment Request Form (2 pages)

The billing provider's W-9 is required and must be submitted with the payer form.

**Note:** The payer will not accept electronic signatures. The agreement must be hand signed.

On bottom of page 1- Provider or Authorized Person must sign.

On bottom of page 2- Provider or Authorized Person must sign, print name and title where indicated. The title of the signer must be one of the following: Provider, Office Manager, or Owner.

#### 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'

### 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 completed MemorialCare form, W-9 form and Office Ally ERA Linkage form to the enrollment record.

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.

**Submission Information**

**Type of Submission**

**Comments**

*Type of submission: New Enrollment, Deactivate Existing ERA, Change Existing ERA.*

**Provider Information**

<b>Name</b>	<input type="text"/>	<b>City</b>	<input type="text"/>
<b>Street Address</b>	<input type="text"/>	<b>Zip Code</b>	<input type="text"/>
<b>State</b>	<input type="text"/>		

**Contact Name**

**Contact Phone Number**

**Contact Email Address**

**Provider Federal Tax Identifier Number**

**Employer Identification Number (EIN)**

**National Provider Identifier (NPI)**

**Submitter Information**

<b>Authorized Submitter Name</b>	Office Ally
<b>Authorized Submitter Title/Position</b>	Customer Service
<b>Authorized Submitter Phone Number</b>	(360) 975-7000
<b>Authorized Submitter Email Address</b>	support@officeally.com

*By signing below, I certify all information is true and correct to the best of my knowledge.*

**Authorized Submitter Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Provider ERA Authorization Form



Important Information (See Instruction #2, 3, 8)

RE: **Electronic Remittance Advice (835) Enrollment Authorization**

Date: \_\_\_\_\_

**Attention:** MemorialCare  
Interoperability Team  
17360 Brookhurst St.  
Fountain Valley, CA. 92708

I hereby authorize Office Ally (**3<sup>rd</sup> Party Vendor/Billing Service Provider**), with an address of, PO Box 872020, City Vancouver, State WA, Zip Code 98687 to receive and transact any and all 835s/ERA's for the **Provider/Group** listed below, having the **Tax ID, Employer Identification Number (EIN)**, and/or **National Provider Identifier (NPI)**, to the clearinghouse listed below:

Provider/Group Name: \_\_\_\_\_

(EIN): \_\_\_\_\_

(NPI): \_\_\_\_\_

Clearinghouse Name: Office Ally

*By signing below, I certify that I am an authorized individual for the Provider/Group, Tax ID(s), and NPI(s) listed in the enrollment form above and that I am authorized to sign on their behalf.*

\_\_\_\_\_  
**Provider Authorized Signature**

\_\_\_\_\_  
**Printed Name of Authorized Individual**

\_\_\_\_\_  
**Title of Authorized Individual**



# 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).