

Preferred IPA 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, SIGN 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.
- EFT enrollment is required. You must include a voided check or bank letter with the EFT form.
- 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. Preferred IPA of California EFT Authorization Agreement (3 pages)

Complete the Provider Contact and Financial Institutional Information sections on Page 1.

In the Submission Information section, check the box for 'New Enrollment' or 'Change Enrollment.'
Also, check the box next to 'Bank Letter' or 'Voided Check.'

Provider or Authorized Individual must print name, title, date, and sign under the Authorized Signature section on Page 2.

2. OfficeAlly 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.



Electronic Funds Transfer (EFT) Authorization Agreement

PROVIDER INFORMATION		
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*Provider Name		
*Provider Address		
Street		
City	State/Province	ZIP Code/Postal Code

PROVIDER IDENTIFIERS INFORMATION									
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*Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)									
*National Provider Identification Number (NPI)									

PROVIDER CONTACT INFORMATION	
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*Provider Contact Name	Title
*Telephone Number () -	
*Email Address	Fax Number () -

FINANCIAL INSTITUTION INFORMATION		
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*Financial Institution Name	Financial Institution Address					
	Street					
City	State/Province	ZIP Code/Postal Code				
*Financial Institution Routing Number	*Type of Account at Financial Institution					
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; border: 1px solid black;"> </td> <td style="width: 25%; border: 1px solid black;"> </td> <td style="width: 25%; border: 1px solid black;"> </td> <td style="width: 25%; border: 1px solid black;"> </td> </tr> </table>					<input type="checkbox"/> Checking <input type="checkbox"/> Saving	

*Provider's Account Number with Financial Institution

*Account Number Linkage to Provider Identifier
<input type="checkbox"/> Provider Tax Identification Number (TIN) _____ (Selection of TIN will indicate EFT applies to entire TIN)

SUBMISSION INFORMATION (Check One)

*Reason for Submission:	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Change Enrollment	<input type="checkbox"/> Cancel Enrollment
*Include with Enrollment Submission	<input type="checkbox"/> Bank Letter	<input type="checkbox"/> Voided Check	

Authorization Agreement – Please read and sign your name below.

Electronic Funds Transfers (EFT)

The undersigned health care provider representative (*Provider*) hereby:

(1) authorizes Preferred IPA to make payments for Provider's services by Electronic Fund Transfer (EFT)

(2) certifies that Provider has selected the following depository institution

(3) directs that all such EFT payments be made as provided below

(4) acknowledges and agrees that provider will no longer receive paper remittance advices (RA) by mail. Provider will receive an ERA (835) via a clearinghouse.

This agreement will remain in effect until I notify Preferred IPA of the desire to cancel or change this service or until Preferred IPA notifies me that this service has been terminated. I understand I must allow reasonable time for my instructions to be executed. I authorize and request the bank listed above to accept any credit entries by Preferred IPA to such account and to credit the same to such account.

AUTHORIZED SIGNATURE The form must be signed by an authorized individual.

By signing below, I hereby agree that I have read and agree to the terms and conditions stated above. Furthermore, the undersigned certifies that the information provided is true and accurate in all respects and that he/she has been duly authorized by all necessary and appropriate action.

* Written Signature of Person Submitting Enrollment

* Printed Name of Person Submitting Enrollment

* Printed Title of Person Submitting Enrollment

Submission Date

All Required Fields are indicated with an Asterisk (*).

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Preferred IPA direct deposits are made.

Definitions

Electronic Funds Transfer (EFT)

PROVIDER INFORMATION	
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider
(Provider Address) Street	The number and street name where a person or organization can be found
City	City associated with provider address field
State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country
ZIP Code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities
PROVIDER IDENTIFIERS INFORMATION	
Provider Identifiers	Enter TIN and NPI information
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions
PROVIDER CONTACT INFORMATION	
Provider Contact Name	Name of a contact in provider office for handling EFT issues
Title	Title of contact
Telephone Number	Associated with contact person
Email Address	An electronic mail address at which the health plan might contact the provider
Fax Number	A number at which the provider can be sent facsimiles
FINANCIAL INSTITUTION INFORMATION	
Financial Institution Name	Official name of the provider's financial institution
Financial Institution Street Address	Street address associated with receiving depository financial institution name field
City	City associated with receiving depository financial institution address field
State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country
ZIP Code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited
Type of Account at Financial Institution	The type of account the provider will use to receive EFT payments, e.g., Checking, Saving
Provider's Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited
Account Number Linkage to Provider Identifier	Provider Tax Identification Number for grouping (bulking) claim payments – TIN Numeric, 9 digits
SUBMISSION INFORMATION	
Reason for Submission	Select your reason for submission from the options available.
Include with Enrollment Submission	Voided check: A voided check is attached to provide confirmation of Identification/Account Numbers Bank Letter: A letter on bank letterhead that formally certifies the account owners routing and account numbers
Authorized Signature	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment
Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity
Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment
Printed Title of Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment
Submission Date	The date on which the enrollment is submitted



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.