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## Redlands-Yucaipa Medical Group 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, SIGN 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.
- EDIinsight is unable to check enrollment status for this payer.
- EFT enrollment is required to receive ERAs from this payer. You must include a voided check or bank letter on bank letterhead with this agreement.

### 835 Electronic Remittance Advice:

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

#### 1. Epic Management EFT and ERA Authorization Agreement (2 pages)

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

Complete the 'Submission Information' section on Page 2.

Provider or Authorized Individual must print name, title, dates, and sign at the bottom of Page 2.

#### 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.

### To return the Epic Management EFT and ERA Authorization Agreement:

Mail to:

Waystar Enrollment Department  
888 W. Market St, Suite 400  
Louisville, KY 40202

### To return the ERA Linkage Form:

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.

The information you provide on this Electronic Funds Transfer and Electronic Remittance Advice Authorization Agreement is used to establish the Trading Partner relationship between Epic Management, L.P. and your organization. By completing and signing this form, your company authorizes Epic Management to transmit remittance advice data in an X12-5010 format and to make electronic payments.

Provider Information		
Provider Name*:		
Doing Business As Name (DBA):		
Street*:		
City*:	State/Province*:	ZIP Code/Postal Code*:

Provider Identifiers Information	
<input type="checkbox"/> Provider Federal Tax Identification Number (TIN) <input type="checkbox"/> Employer Identification Number (EIN)*	
National Provider Identifier (NPI) (Submit additional NPIs on a new sheet of paper)*:	
Assigning Authority*:	

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

Financial Institution Information		
Financial Institution Name*:		
Street*:		
City*:	State/Province*:	ZIP Code/Postal Code*:
Financial Institution Telephone Number:		
Financial Institution Routing Number*:		
Provider's Account Number with Financial Institution*:		
Type of Account at Financial Institution* (select one):		
<input type="checkbox"/> Checking account <input type="checkbox"/> Savings account		
Account Number Linkage to Provider Identifier*: <input type="checkbox"/> Provider Tax Identification Number (TIN) <input type="checkbox"/> National Provider Identifier (NPI)		
<i>If enrolling in the 835 Electronic Remittance Advice (ERA), the provider must contact its financial institution to arrange for the</i>		



**Epic Management Electronic Funds Transfer (EFT) and  
Electronic Remittance Advice (ERA) Authorization Agreement**

*delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the 835 ERA.*

**Vendor Information**

Vendor Name

Vendor Contact Name

Telephone Number

Email Address

**Submission Information**

Reason for Submission (Only for ERA. Contact Epic Management to change or cancel enrollment in Electronic Funds Transfer)\*:

New Enrollment

Change Enrollment

Cancel Enrollment

A voided check from the provider's account or a letter from the financial institution on financial institution letterhead specifying the provider's name, the account and financial institution routing/ABA number must be included with the signed EFT Authorization Agreement.

Voided check

Bank letter

**Authorization**

**EFT Only**

*I hereby authorize Bank of America, on behalf of Epic Management L.P., to deposit by electronic funds transfer, payments owed to the aforementioned provider, and if necessary, debit entries and adjustments for any amounts deposited in error. Bank of America shall deposit the payments in the designated financial institution's account. I recognize that if I fail to provide complete and accurate information on this Authorization Agreement, the processing of the Agreement may be delayed or my payments may be erroneously transferred electronically. Epic Management L.P. shall have no liability or responsibility for any payments erroneously transferred.*

*I affirm all of the information contained in this enrollment application to be correct and true to the best of my knowledge. I understand that providing false or misleading information on this enrollment application will result in rejection from the EFT payment program and that I will be responsible for any fees, legal or otherwise, incurred by Epic Management L.P. on my behalf. By signing below, I hereby agree that I have read and agree to the terms and conditions. Furthermore, the undersigned certifies that the information provided is true and accurate and that they have the authority to sign this form*

Authorized Signature\*:

Submission date\*:

Printed name of person submitting enrollment\*:

Printed title of person submitting enrollment\*:

Requested ERA Start/Change/Cancel Date:

This EFT / ERA Authorization Agreement must be fully completed, signed and returned via U.S. Mail to:

Epic Management L.P.  
Claims Department c/o Craig Hewitt  
1615 Orange Tree Lane  
Redlands, CA 92374

If you have any questions regarding the EFT / ERA enrollment process, contact our Claims Department by telephone at 909-799-1818 or by email at [Claims@epiclp.com](mailto:Claims@epiclp.com).



# 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).