
Physicians Medical Group of San Jose
Excel MSO
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 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 15 days.
- Support Vendors may contact the EDIinsight Enrollment Team to follow up on the ERA setup request. Or contact the payer at Providerservices@excelmso.com.

835 Electronic Remittance Advice:

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

1. PMGSJ / Excel MSO 835 Enrollment Request (1 page)

Complete the 'Provider Contact Information' and 'Electronic Remittance Advice Information' sections.
Choose your 'Reason for Submission' under the 'Submission Information' section.
Provider or Authorized Individual must sign where indicated.

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 EDIinsight Enrollment Team:

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.



PMGSJ / EXCEL MSO (EXC01) 835 ENROLLMENT REQUEST

Email this form to Providerservices@excelmso.com or Fax to (408) 937-3639. Please make sure to print legibly and to complete this form in its entirety. You risk delaying enrollment if the application is unreadable or incomplete.

PROVIDER INFORMATION:

Provider Name:

Provider Address:

City:

State:

Zip:

PROVIDER IDENTIFIER INFORMATION:

**Provider Federal Tax Identification Number (TIN)
OR Employer Identification Number (EIN):**

National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION:

Provider Contact Name:

Telephone Number/Ext:

Email Address:

Fax Number:

ELECTRONIC REMITTANCE ADVICE INFORMATION:

Preference for Aggregation of Remittance Data: (i.e. Account Number Linkage to Provider Identifier). Provider preference for grouping (bulking) claim payment advice must match preference for EFT payment (i.e. Billing Provider). Choose only one.

Provider Federal Tax Identification Number (TIN):

National Provider Identifier (NPI):

SUBMISSION INFORMATION:

Reason for Submission:

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.