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## Prospect 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 30 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. Prospect Medical Electronic Remittance Advice Enrollment Form (2 pages)

Complete the 'Provider Contact Info' section on Page 1.

Check the box next to your ERA Aggregation Preference.

Check New Enrollment or Change Enrollment for your Submission Reason.

Provider or Authorized Individual must print date, name, title and sign at the bottom of Page 1.

#### 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.



PROSPECT MEDICAL

# Electronic Remittance Advice Enrollment Form

Processing time is 5-7 business days

Return completed form to: [ERAenrollment@prospectmedical.com](mailto:ERAenrollment@prospectmedical.com)

## PROVIDER INFO

Name:		
Address:		
City:	State:	Zip/Postal Code

## PROVIDER IDENTIFIERS

Tax Identification Number (TIN/EIN):	National Provider Identifier:
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## PROVIDER CONTACT INFO

Contact Name:	Title:	
Telephone:	Extension:	Email:

## ERA AGGREGATION PREFERENCE:

Provider preference for grouping claim payment remittance advice

- Provider Tax Identification Number (TIN)       National Provider Identifier (NPI)

## CLEARINGHOUSE INFORMATION

Clearinghouse Name: <b>Office Ally</b>
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## SUBMISSION REASON

- NEW Enrollment       CHANGE Enrollment       CANCEL Enrollment

The undersigned hereby certifies that the information provided herein is true and accurate in all respects and that the person has been duly authorized by all necessary and appropriate corporation action, where applicable, to execute this agreement on behalf of the above-mentioned Provider to form a legally binding contract. The undersigned authorizes Prospect Medical Systems (PMS) on its behalf and on behalf of its contracted medical groups to transmit electronic remittance advice (ERA) detail for claims processed by PMS to the provider listed above. In addition, the undersigned hereby agrees that upon completion of enrollment processing, PMS will concurrently send paper remittance and ERA for a period of 31 calendar days, after which time provider will only receive ERA. This Authorization is to remain in full force and effect until PMS has received written notification from Provider of its termination in such time and manner as to afford PMS a reasonable opportunity to act on it.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Authorized Signature

Title



## Electronic Remittance Advice (ERA)

### Enrollment Form Instructions

#### *Provider Info*

**Provider Name:** Enter legal name for institution, practice or provider

**Provider Address:** Enter physical street address, City, State, and Zip code

#### *Provider Identifiers*

**TIN/EIN:** Enter provider's Federal Tax Identification Number or Employer Identification Number

**NPI:** Enter provider's National Provider Identifier

#### *Provider Contact Info*

**Contact Name:** Enter the name of an individual who can be contacted about ERA enrollment

**Telephone:** Enter telephone number for provider contact   **Extension:** Enter phone extension (*if applicable*)

**Email:** Enter email address for provider contact

#### *ERA Aggregation Preference*

**TIN Aggregation:** Selection designates ERA to be aggregated by TAX Identification Number

**NPI Aggregation:** Selection designates ERA to be aggregated by National Provider Identification Number

#### *Clearinghouse Information:*

**Clearinghouse Name:** Enter Clearinghouse Name that will receive ERA

#### *Submission Reason:*

**New Enrollment** – select this option to enroll in ERA for the first time

**Change Enrollment** – select this option to edit/modify existing ERA enrollment

**Cancel Enrollment** – select this option to terminate any future ERA transmissions

#### *Signature*

**Authorized Signature:** Signature of person authorized, to initiate, modify, or terminate enrollment on behalf of provider.

**Date:** Enter the date on which the enrollment is submitted.

**Printed Name:** Enter the printed name of person signing the ERA enrollment form



# 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).