eSolutions
Strengthen your revenue health
EDI Insight

Payer ID: MHC01

Mountain Health CO-OP

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 15 days.
- Support Vendors may contact the EDIinsight 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. **835 Electronic Remittance Advice (ERA) Enrollment Form (Page 1)**

COMPLETE AND SIGN the form using the provider's billing/group information as credentialed with the payer.

2. **Authorization Agreement for Electronic Transfer of Funds (Page 2)**

CHECK corresponding boxes at top of Page 2.

COMPLETE AND SIGN the form using the provider's billing/group information as credentialed with the payer.

3. **OPTUM (Page 3)**

COMPLETE all provider information as credentialed with the payer.

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(s).
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.

MOUNTAIN HEALTH CO-OP

835 ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT FORM

Please complete the following information:

☑ **Activate Enrollment: Date: ____/____/_____** **____Terminate Enrollment: Date: ____/____/_____**

Provider Name: _____

Provider Address: _____ **City:** _____ _____

State: ____ **Zip Code:** _____-_____ **Provider Contact:** _____

Provider Phone Number: (_____)-_____-_____

Provider Tax Identification Number (TIN): _____

Provider National Provider Identifier (NPI):_____

Clearinghouse Name: Change Healthcare

Vendor Name: _____

This authority is to remain in full force and effect until HealthPlan Services has received written notification from me on its termination in such time and such manner as to afford HealthPlan Services a reasonable time to act on notification.

Authorized Signature: _____ **Date: ____/____/_____**

Electronic Remittance Advise (ERA) – New Enrollment

AUTHORIZATION AGREEMENT FOR ELECTRONIC TRANSFER OF FUNDS

I Hereby authorize and request Mountain Health Co-Op, as claims administrator to initiate credit entries as designated owing to me for services rendered to the account indicated below in the depository financial institution named below, hereafter called DEPOSITORY. This request becomes EFFECTIVE WITHIN TWO WEEKS OF RECEIPT OF THIS DOCUMENT. Thereafter, credits for services rendered will be direct deposit. It is very important that you verify account and ABA numbers with your Depository Institution. Incorrect format can lead to rejection or delay of the funds.

☐ New Authorization ☐ Termination ☐ Replace Current

☐ Savings or ☐ Checking _____ Depository Institution _____ ABA/Transit Number* _____ Account Number

Bank Contact Information _____ Name _____ Telephone Number

Provider Email _____

This authority is to remain in full force and effect until WHPS has received written notification from me on its termination in such time and in such manner as to afford WHPS a reasonable time to act on it.

TAX IDENTIFICATION NUMBER _____ DATE: _____

PROVIDER NAME _____ (Please Print) SIGNATURE _____

NOTE: Please attach either a voided blank check for Checking or savings account deposit slip for Savings account changes or complete banking information on the bank's letterhead is required to complete the request.
Email completed documents to: WHPS.ASOMHCproviderservices.ext@wipro.com

* Bank's routing number taken from the MICR line of the recipient's check.
The first digit should be 0, 1, 2, or 3. A routing number starting with 4-9 is usually not valid.

Revised 08/15/24

Optum requires the following information to set up our system internally.

Provider Name:

National Provider Identifier (NPI):

Provider Federal Tax Identification Number (TIN)
or Employer Identification Number (EIN):

Provider Address:

Provider City: State: Zip Code:

Contact First Name:

Contact Last Name:

Contact Phone:

Contact Email: