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## **iCare Health Options (FL Optometric Phys.)**

### **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 10 days.
- Support Vendors may contact the EDIinsight Enrollment Team to follow up on the ERA setup request.

#### **837 Claims Enrollment**

--If submitting request for 835 ERAs, SKIP TO NEXT SECTION for 835 Enrollment, which will include 837.

--If the provider does NOT want to receive 835 ERAs from this payer...

**SEE THESE STEPS ONLY** for 837 Claim Enrollment --

Within EDIinsight - Enrollment Manager:

GO TO Enrollment record or **[ADD Payer Enrollment]**, SELECT **[PROF CLAIM]** for Claim transaction.

CLICK **[SUBMIT Enrollment]** ENTER note advising request is for 837 Claims' enrollment only.

#### **835 Electronic Remittance Advice (835) Enrollment Form (Provider will also be enrolled for 837 Claims).**

- SEE iCare Health Solutions form on NEXT 3 pages.
- COMPLETE the form with billing provider information.
- VERIFY all the information on the form is correct.
- On Page 2- Provider or Authorized Person must print, sign, and date.
- Page 3 can be left blank, if there are no additional tax IDs.

#### **Submit to EDIinsight Enrollment Team:**

Within EDIinsight - Enrollment Manager:

GO TO enrollment record 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.

**835 Healthcare Electronic Remittance Advice  
(ERA) Request/Certification Form**



**General Instructions**

This form is designed for providers who want to receive a HIPAA X12N 835 version 5010 A1 electronic remittance (ERA) transaction (Raw Data File) from Medegy Health Systems.

**Form must be completed IN FULL. Please type or print clearly.**

A. Provider Information (To be completed by the Provider Office)		
Individual Provider <input type="checkbox"/> Group/Practice <input type="checkbox"/> Facility <input type="checkbox"/>		
Other _____		
Provider/Group Name:	Provider Contact Name:	
Provider Business Address:	Provider City/State/Zip	
Provider Contact Phone:	Provider Email Address (REQUIRED)	
Provider Tax ID:	Multiple Tax ID's (Check if applicable and see Attachment 1) <input type="checkbox"/>	
B. TPA/Billing Agency Information (FILL OUT ONLY IF APPLICABLE)		
<b>Instructions:</b> This section is for the vendor that supports your electronic remittance advice software and/or delivers the 835 Health Care Electronic Advice to you.		
Type of service used to receive electronic transactions (835): TPA <input type="checkbox"/> Billing Agency <input type="checkbox"/>		
<b>If using a Billing Agency, complete section B.1 only. If using a TPA, complete sections B.1 and B.2.</b>		
B.1: Completion Required. The TPA/Billing Agency must complete this section.		
TPA/BA Name:	Contact Name:	
Contact Phone:	Contact Email Address:	Contact Fax Number:

**B.2: Complete if using a TPA.**

TPA (if 835's not delivered)

Contact Phone:

Contact Email Address:

Contact Fax Number:

**Provider/Vendor Certification**

The undersigned Healthcare Provider \_\_\_\_\_ hereby certifies to Medegy Health Systems the following with respect to the 835 Electronic Remittance Advice.

**Approved by:**

Authorized Representative (sign below):

Title:

Printed Name:

Date:

Print and email completed ERA forms to: [EDISupport@medegy.com](mailto:EDISupport@medegy.com)

