Electronic Remittance Advice (835) and EFT Authorization Agreement

Please complete all applicable sections. Submit a copy of your W-9 with this completed form to us through secure encryption to spenddown@nascentiahealth.org or mail the completed form to the address on page 2 of this form.

Please type or print legibly in black or blue ink. IMPORTANT: ALL applicable sections MUST be completed. For example: If you are already enrolled for EFT and are now adding ERA, then unless the EFT section is filled out again, you will be disenrolled from EFT.

Provider Information

I wish to enroll in (choose one): ☐ EFT and 835/ERA ☐ EFT only ☐ 835 only

Provider Name (as it appears on the W-9): _____

Street: _____ City: _____ State: _____ ZIP: _____

Provider Federal Tax Identification Number (TIN): _____ National Provider Identifier (NPI): _____

Provider Contact Name: _____ Phone: _____

Email Address: _____

Bank Information (please complete for EFT enrollment)

Financial Institution Name: _____

Name on Bank Account: _____

Street: _____ City: _____ State: _____ ZIP: _____

Financial Institution Routing Number: _____ Type of Account at Financial Institution: ☐ Checking ☐ Savings

Provider's Account Number with Financial Institution: _____

Clearinghouse Information (please complete for Electronic Remittance Advice enrollment)

Reason for submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Clearinghouse Name: ☐ Change Healthcare (Previously Emdeon) ☐ Availity ☐ Office Ally ☐ Waystar

Clearinghouse Contact Name and Number _____

I wish to continue to receive paper remittance, in addition to ERA:

☐ Yes ☐ No (* if no option is selected, provider will be disenrolled from receiving paper remittance)

Disclosure

By submitting this form, I authorize the above-named contact person to execute, implement, and perform all functions necessary for my facility to receive electronic funds transfer (EFT) payments, and (if requested) electronic remittance advice, from Nascentia Health Plans.

Printed Name of Person Submitting Enrollment _____

Signature Name of Person Submitting Enrollment _____

Printed Title of Person Submitting Enrollment _____

Submission Date _____

See page two for terminology.

EFT/ERA Enrollment Glossary of Terms

Provider Information

- **Provider Name** – Complete legal name of institution, corporate entity, practice, or individual provider.
- **Street** –The number and street name where a person or organization can be found.
- **City** – City associated with provider address field.
- **State/Province**– ISO 3166-2TwoCharacter Code associated with the State/Province/Region of the applicable Country.
- **ZIP** – System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.
- **Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)** – A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.
- **National Provider Identifier** – A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
- **Provider Contact Name** – Name of a contact in provider office for handling EFT/ERA issues.
- **Phone** – Number associated with contact person.
- **Email Address** – An electronic mail address at which the health plan might contact the provider.

Bank Information

- **Financial Institution Name** – Official name of the provider's financial institution.
- **Street** – Street address associated with receiving depository financial institution name field.
- **City** – City associated with receiving depository financial institution address field.
- **Financial Institution Routing Number** – A nine-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited.
- **Type of Account at Financial Institution** – The type of account the provider will use to receive EFT payments, e.g., Checking, Savings.
- **Provider's Account Number with Financial Institution** – Provider's account number at the financial institution to which EFT payments are to be deposited.
- **Clearinghouse Name** – Official name of the provider's clearinghouse.
- **Clearinghouse Contact Name and Number** – Name and number of a contact in clearinghouse office for handling ERA issues.
- **I wish to continue to receive paper remittance, in addition to ERA** – Choose whether to receive paper remittance, a printed notice mailed to providers explaining how billing transactions are processed (paid, rejected, or denied), in addition to ERA.

Disclosure

- **Authorized Signature** – The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment.
- **Printed Name of Person Submitting Enrollment** – The printed name of the person signing the form may be used with electronic and paper-based manual enrollment.
- **Printed Title of Person Submitting Enrollment** – The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment.
- **Submission Date** – The date on which the enrollment is submitted.
- **Requested ERA Effective Date** – Date the provider wishes to begin ERA; per Phase III CORE Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0: there may be a dual delivery period depending on whether the entity has such an agreement with its trading partner.

Mailing Address:

Nascentia Health
Attn: Claims Manager
1050 West Genesee St
Syracuse, NY 13204