

## EFT (Electronic Funds Transfer) and ERA (Electronic Remittance Advice) Enrollment Form

## **INSTRUCTIONS**

- » This is a fillable form. Type your information into the form on your screen, or print the form and fill in the information.
- » Complete all sections that apply to your enrollment choice (EFT, ERA, or both EFT and ERA).
- » Enrollments are handled at the TAX ID level. All NPIs associated with the specified TIN will be automatically enrolled.
- » If your TAX ID would like to receive payments via more than one bank account, please contact EDI@EchoHealthinc.com.
- » Be sure to sign the form. Fax, postal mail or email the completed form (secure email is recommended if you choose this method) to: ECHO Health, Inc., 810 Sharon Drive, Westlake, OH 44145.
- » For information about the status of your enrollment, or for any other questions, please contact ECHO at 440.835.3511 or EDI@EchoHealthinc.com.

Payer / Insurar	ice Compan	y Name: _				
-	-			Please specify of	nly one Payer per form)	
					o validate against your Tax ID. The Draft Number mber and Draft Amount are <i>not required</i> .	
ECHO Draft Number			ECHO Draft Amount \$			
1-Form Select (Re	equired)					
EFT & E	RA EF1	Only	ERA Only			
2-Provider Inform	nation (Requi	red)				
Provider Name:	/0 /					
	(Comple	ete legal name	e of institution, corporate	entity, practice or	individual provider)	
Street:	(The second leaves to the second	-1 -44		!#! b #		
	The number and	a street name	where a person or organ	ization can be fol		
City: (City associated	Lwith provider o	ddraga fiold)	State/ Province:	Character	ZIP Code/Postal Code:  (System of postal-zone codes [zip stands	
(Gity associated	i with provider a	aaress lielaj	(ISO-3166-2 Tv Code associat State/Province/F applicable Coun	ed with the Region of the	for "zone improvement plan"] introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.)	
3-Provider Identil	iers Informa	ntion (Requi	red)			
Provider Identif	iers					
			e <b>r (TIN) or Employer I</b> un as an Employer Identif		Number (EIN):  EIN], is used to identify a business entity)	
Does provider ha	ve a National	Provider Id	entifier (NPI) Numbe	r? Yes	No	
If "Yes," enter NF	I. National Pr	ovider Iden	tifier (NPI):			
(A Health Insurance covered healthcare pand financial transaction numbers do not carr	Portability and A providers. Coven tions adopted ui y other informati	Accountability A ed healthcare nder HIPAA. T ion about heal	Act (HIPAA) Administrativ providers and all health p he NPI is a 10-position, in	lans and healthca ntelligence-free no the state in which	Standard. The NPI is a unique identification number is are clearinghouses must use NPIs in the administrati umeric identifier (10-digit number). This means that to the they live or their medical specialty. The NPI must	

<ul> <li>4-Provider Contact Information</li> </ul>	mation (Required for EFT Only or for EFT & ERA "Form Select" choice)
Drovider Centest Name	
Provider Contact Name:	
	(Name of contact in provider office for handling EFT issues)
Telephone Number:	E-mail Address:
=	with contact person) (An electronic mail address at which the health plan might contact the provider)
(Associated V	(An electronic mail address at which the health plan might contact the provider)
4A-Provider Contact Info	ormation (Required for ERA Only or for EFT & ERA "Form Select choice)
Provider Contact Name:	
Provider Contact Name.	
	(Name of contact in provider office for handling ERA issues)
Telephone Number:	E-mail Address:
	with contact person) (An electronic mail address at which the health plan might contact the provider)
(* 1000 ).410 4	( o.o o.o. o.o. o.o. o.o. o.o. o.
5-Provider Agent Informa	ation (If Applicable and you selected EFT Only or EFT & ERA "Form Select" choice)
Provider Agent Name:	
1 Tovider Agent Name.	(Name of provider's outherized arent)
	(Name of provider's authorized agent)
Provider Agent Contact N	lame:
•	(Name of contact in agent office for handling EFT issues)
Telephone Number:	E-mail Address:
(Associated with contact perso	on) (An electronic mail address at which the health plan might contact the provider)
5A-Provider Agent Inforn	mation (If Applicable <u>and</u> you selected <b>ERA Only</b> or <b>EFT &amp; ERA</b> "Form Select" choice)
Provider Agent Name:	
1 Tovider Agent Name.	(Name of provider's outborized exent)
	(Name of provider's authorized agent)
Provider Agent Contact N	lame:
	(Name of contact in agent office for handling ERA issues)
Talambana Numban	
Telephone Number:	E-mail Address:
(Associated with contact perso	(An electronic mail address at which the health plan might contact the provider agent)
6 Financial Institution In	formation (Required for EFT Only or for EFT & ERA "Form Select" choice)
0-1 mancial mistitution mi	Internation (Negative In I only of the LTA Tollin Select Choice)
Fire and in Localitation Name	
Financial Institution Name	e:
	(Official name of the provider's financial institution)
Financial Institution Routi	ing Number
(A 9-digit id	dentifier of the financial institution where the provider maintains an account to which payments are to be deposited)
Type of Account at Finance	cial Institution:
	(The type of account the provider will use to receive EFT payment, e.g., Checking, Saving)
	(The type of decount the provider will decide to receive Er.) payment, e.g., encouning, eaving)
Provider's Account Numb	per with Financial Institution:
	(Provider's account number at the financial institution to which EFT payments are to be deposited)
	(i rovider a account number at the illiandal illistitution to which Li 1 payments are to be deposited)
Account Number Linkage	to Provider Identifier. Select one option below.
	ing [bulking] claim payments – must match preference for v5010 X12 835 advice)
	iffication Number (TIN)  National Provider Identifier (NPI)

7-Electronic Remittance Advice	ce Information (Required for ERA Only or EFT & ERA "Form Select" choice)
	Remittance Data (e.g., Account Number Linkage to Provider Identifier)  king] claim payment remittance advice – must match preference for EFT payment)
Does provider have a National P	Provider Identifier (NPI) Number? Yes No
Provider Tax Identification Nu	umber (TIN):
	(Required if NPI is not applicable)
National Provider Identifier (N	NPI):
	(Required if TIN is not applicable)
Method of Retrieval:	
(The method in which the provider	er will receive the ERA from the health plan [e.g., download from health plan website, clearinghouse, etc.]
8-Flectronic Remittance Advice	ce Clearinghouse Information (Required for ERA Only or EFT & ERA "Form Select" cha
Clearinghouse Name:	e clearing nouse information (Required for ERA Only of EFT & ERA Form Select Cité
Oleaninghouse Hame.	(Official name of provider's clearinghouse)
Clearinghouse Contact Name	12
Clearinghouse Contact Name:	(Name of a contact in the clearinghouse office for handling ERA issues)
	,
Clearinghouse Telephone Number	(Telephone number of contact)
Clearinghouse E-mail Address:	(An electronic mail address at which the health plan might contact the provider's clearinghouse)
	() the closuronia main additional at which the median plant might contact the provider a dicamignously
Vendor Name:  Vendor Contact Name:	(Official name of provider's vendor)  (Name of a contact in vendor office for handing ERA issues)
Vendor Telephone Number:	
	(Telephone number of contact)
Vendor Email Address:	
Volladi Elliali Addi 000.	(An electronic mail address at which the health plan might contact the provider's vendor)
10-Submission Information (Re	'equired)
Reason for Submission: N	New Enrollment Change Enrollment Cancel Enrollment
Printed Name of Person Submitt	ting Enrollment:
(The printed name	e of the person signing the form; may be used with electronic and paper-based manual enrollment)
Submis	ission Date (YYYYMMDD):
	(The date on which the enrollment is submitted)
Authorized Signature (The signatu May be used with electronic and paper	ure of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. or-based manual enrollment).
and conditions for Quick Post	cknowledges that the provider has read, agrees that it is subject to and agrees to comply with all terms t Advisor enrollment, including those relating to the delivery of the services, which can be found at: <a href="mailto:m/EFTERA/termandcondition.aspx">m/EFTERA/termandcondition.aspx</a> .
Signature of Davoon	
Signature of Person	Submitting Enrollment:
_	g of a name unique to a particular person used as confirmation of authorization and identity)