eSolutions

CARE 1ST Health Plan of Arizona
835

EDI Enrollment Instructions:

- Please save this document to your computer. Open the file in the Adobe Reader program and type directly onto the form.
- ERA enrollment is set up between CARE 1ST and the Provider. ERAs are accessed through the CARE 1ST Provider Portal once set up is complete.
- CARE 1ST may or may not agree to generate ERA based on the provider's claim volume.
- EFT must be set up to qualify a provider for ERA enrollment consideration.
- EDI enrollment timeframe is approximately 30 days.
- To check status of EDI enrollment, please contact Care 1st at 602-778-1800, Opt. 5, Opt. 7.

837 Claim Transactions:

EDI enrollment applies to ERA only and is not necessary prior to sending claims.

835 Electronic Remittance Advice:

Enrolling for ERA with CARE 1ST is a **two-step** process:

1. The Provider must set up EFT with CARE 1ST before requesting ERA. Complete the attached **CARE 1ST Electronic Funds Transfer (EFT) Authorization Form**.
   Fax completed document and a voided check to CARE 1ST at **602-778-1875**.

2. Request ERA by completing the table below. Complete the fields using the provider's billing/group information as credentialed with this payer. Click on "Submit by Email" button to generate an email direct to the payer. A CARE 1ST representative will contact you.

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION FORM

Complete appropriate sections below, attach voided check, deposit slip or letter from financial institution and return to Provider Network Operations:

FAX TO: 602-778-1875

QUESTIONS: 602-778-1800 (Options 5, 7)

Section I ☐ New EFT Setup ☐ Change in Account Number ☐ Change in Account Type ☐ Change in Financial Institution
☐ Cancellation Request (complete sections II, III and V only)

Section II **PAYEE IDENTIFICATION**

Federal Employer's Identification Number (EIN: _____-_______________

Or Social Security Number (SSN): _______-_____-______
(Disclosure of your Social Security Number is voluntary pursuant to 42 USC 405(c)(2)(C). The State of Arizona will use your SSN or EIN to file required information returns with the Internal Revenue Service)

_______________________________ Payee Name (provider) ____________________ Business Phone ____________________ Business Fax

____________________ AHCCCS/Medicare ID# ____________________ NPI# ________________________________ Email Address

________________________________ Address ____________________ City ______ State _________ Zip Code

Section III **AUTHORIZATION FOR SETUP, CHANGES OR CANCELLATION**

I authorize Care1st to process payments owed to me via Electronic Funds Transfer (EFT) deposits. Care1st shall deposit the electronic payments in the financial institution and account designated below.

I certify that I have read and agree to comply with Care1st rules, governing payments and electronic transfers as they exist on this form or as subsequently adopted, amended, or repealed. I certify that I am authorized to initiate electronic funds transfer (EFT) for the entity receiving deposits, pursuant to this agreement, and that all information provided is accurate.

_______________________________ Signature (Required) ____________________________ Title ___________ Date

Section IV **FINANCIAL INSTITUTION**

Bank Name:____

Bank Address:_____________________________________ City_________ State:_______ Zip Code____________

Branch Phone Number: _____-______-________

Routing transit number: ______________________________ Customer Account Number:_____________________

Type of Account: Checking ☐ Savings ☐ Lockbox ☐

Attach voided check (checking acct) or deposit slip (savings acct) when submitting. If a voided check is not available, please request a letter from your financial institution on bank letterhead, which reflects the routing and account numbers. Forms presented without a copy of voided check, deposit slip, or bank confirmation will be retuned to the requestor, unprocessed. Confirmation of EFT setup will be faxed once complete.

Section V **CANCELLATION**

Reason:____ Date: __________________

FOR INTERNAL USE ONLY: Vendor # __________________________ EC# _____________________________

Set Up Completed By/Date _____________________________________ EFT projected for claims paid the week of ______________________

Confirmation Sent to Provider via Fax / Email on ___________________by ____

Revised: 12.2015