eSolutions
Strengthen your revenue health

Payer ID: 11303

Magnacare
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.
- **Electronic Funds Transfer (EFT) is required to receive the Electronic Remittance Advice (ERA).**
- Complete the form using the provider's **billing/group information as credentialed** with this payer.
- Once completed, save for your records, **print and obtain appropriate signature(s)**.
- EDI enrollment processing timeframe is approximately **30 business days**.
- To check status of EDI enrollment, please contact Magnacare EDI at: edienrollment@magnacare.com

837 Claim Transactions:

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

835 Electronic Remittance Advice:

Electronic Remittance Advice (ERA) Authorization Agreement
Complete all applicable fields.
Confirm that your choice for "Reason for Submission" on page 1 is correct (**New or Change**).
All ERA delivery is based on **aggregation of Federal Tax Identification Number (TIN)**.
Please note: Magnacare providers will not receive EFT/ERA for all payments.
There are exception cases where an ERA/835 is not created.

Submit Completed Document:

Email or Fax to both Magnacare and Enrollment:
edienrollment@magnacare.com **or Fax 516-723-7397 AND**
ESH@claimremedi.com **or Fax 913-273-2455**

MAGNACARE℠

Electronic Remittance Advice (ERA) Authorization Agreement

- THIS ERA AUTHORIZATION AGREEMENT FORM MUST BE FULLY COMPLETED, SIGNED AND RETURNED VIA FAX (516.723.7397) OR EMAIL (EDIENROLLMENT@MAGNACARE.COM).
- REQUIRED: A bank account in which to deposit electronic funds and a clearinghouse/software vendor with the ability to accept the ERA file in 835 HIPAA standard format.

Reason for Submission (select one) New Enrollment Change Enrollment Cancel Enrollment

Provider Information

Provider Type Physician Physician Group Ancillary Hospital

Provider Name ____________________

Provider Street Address ____________________

City ____________________ State ____________________ Zip Code ____________________

Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) ____________________

National Provider Identifier (NPI) ____________________

Provider Contact Name ____________________ Phone Number ____________________

Email Address ____________________ Fax ____________________

ERA Information - Preference for aggregation of remittance data is Federal Tax Identification Number (TIN) provided above.

ERA Trading Partner/Receiver

If, as the provider, you are authorizing an Agent, Clearinghouse or Vendor to conduct the 835 transaction, select only one of the following. MagnaCare will contact the selected entity to initiate these transactions.

Agent Clearinghouse Vendor

ERA Trading Partner/Receiver Information

If you are operating as an ERA Trading Partner/Receiver, in order to receive the ERA/EFT on behalf of a provider the provider must either complete the enrollment documents authorizing you to retrieve their remittance files, or a copy of the business associate agreement between you and the provider must be submitted along with this form.

ERA Trading Partner/Receiver Name ____________________

Contact Name ____________________ Phone Number ____________________

Email Address ____________________ Fax ____________________

MAGNACARE[SM]

Electronic Remittance Advice (ERA) Authorization Agreement

Method of Retrieval

FTP setup, connectivity & file transmission protocol.

User ID and Password must be at least 6 characters and include at least 1 numeric character & 1 uppercase letter.

	FTP HOST	FTP SERVER	USER ID	PASSWORD	TRANSFER PROTOCOL
INBOUND TO MAGNACARE	ITBBS.MAGNACARE.COM	MAGNACARE			SSL FTP+PGP
OUTBOUND TO MAGNACARE	ITBBS.MAGNACARE.COM	MAGNACARE			SSL FTP+PGP

Authorized Signature of Person Submitting Enrollment

The authorization is to remain in effect until written notice is submitted to MagnaCare via an ERA Authorization Agreement marked as a cancellation or change form. Any changes to the provider's agent, clearinghouse or vendor must be submitted on an ERA Authorization Agreement form as a change. The termination or change shall be effective 20 days subsequent to MagnaCare's receipt of the updated form.

Printed Name ______________________ Printed Title ______________________

Requested ERA Effective Date ______________ Submission Date ______________________

Sign Here ____

MAGNACARE℠

Electronic Funds Transfer (EFT) Authorization Agreement

THIS ERA AUTHORIZATION AGREEMENT FORM MUST BE FULLY COMPLETED, SIGNED AND RETURNED VIA FAX (516.723.7397) OR EMAIL (EDIENROLLMENT@MAGNACARE.COM).

Reason for Submission (select one) New Enrollment Change Enrollment Cancel Enrollment

Include with Enrollment Submission Voided Check Bank Letter

Provider Information

Provider Type Physician Physician Group Ancillary Hospital

Provider Name ______________________________

Provider Street Address ______________________________

City ______________ State ______________ Zip Code ______________

Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) ______________

National Provider Identifier (NPI) ______________________________

Provider Contact Name ______________ Phone Number ______________

Email Address ______________ Fax ______________

Financial Institution Name ______________________________

ABA Routing Number ______________ Account Number ______________

Type of Account Checking Savings

Preference for Account Number Linkage to data is Federal Tax Identification Number (TIN).

Authorized Signature of Person Submitting Enrollment

Provider expressly authorizes MagnaCare to credit entries (or, if necessary, debit entries and adjustments for any credit entries made in error) to the above-referenced Bank Account number. Provider accepts responsibility for any resulting loss of payment and releases MagnaCare from any liability for or arising from Provider's failure to submit accurate or updated information to MagnaCare relating to the Bank Account. This authorization is to remain in effect until written notice in the form of an EFT cancellation or change is submitted to MagnaCare. The termination or change shall be effective 10 days subsequent to MagnaCare receipt of the updated form.

Printed Name ______________ Printed Title ______________

Requested EFT Start/Change/Cancel Date ______________ Submission Date ______________

Sign Here ______________________________