Payer ID: Per the payer list

Network Medical Management
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.
- Complete the form using the **group/billing information as credentialed** with the payer.
- Once completed, save for your records, print and obtain appropriate signature(s).
- EDI enrollment processing timeframe is approximately **15 business days.**

837 Claim Transactions:

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

835 Electronic Remittance Advice:

Complete the **Electronic Remittance Advice (ERA) Enrollment Form**
Complete all sections as appropriate.
Sign and submit direct to the payer.

Provider must Submit Completed Documents:

Email or Fax to

ProviderNetworkOperations.Dept@nmm.cc
626-943-6309

ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT FORM

Electronic Remittance Advice (ERA/835) files are electronic transactions that contain the same information as your paper remittances. **Please complete the sections below in its entirety and send to the following: FAX (626) 943-6309, via email, ProviderNetworkOperations.Dept@nmm.cc**

- ☐ Advantage Health Network (ADV)
- ☐ Adventist Health Physicians Network (GAMC / WMMC)
- ☐ Greater San Gabriel Valley Physicians (GSGP)
- ☐ Community Family Care IPA (CFC)
- ☐ Access Primary Care Medical Group (APCMG)
- ☐ Arroyo Vista Family Health Center (AVISTA)
- ☐ LaSalle Medical Associates (LSMA)
- ☐ Alpha Care Medical Group (ACMG)
- ☐ Accountable Health Care (AHCIPA)
- ☐ Citrus Valley IPA (CVIPA)
- ☐ Greater Orange Medical Group (GOM)
- ☐ Other _____

PROVIDER INFORMATION	
Contracted Provider Group Name:	
Provider Main Office Address:	
Authorized Contact Person:	
Authorized Contact Person Phone:	
Authorized Contact Person Email:	
PROVIDER IDENTIFICATION INFORMATION	
Federal Tax ID:	
Group NPI:	
Individual Provider NPI(s):	
ELECTRONIC REMITTANCE ADVICE INFORMATION (ONLY CHECK ONE BOX) Preference for Aggregation of Remittance Data: (i.e., Account number linkage to Provider identifier). Please note, preference for grouping claim payment advice, must match preference for EFT payment (i.e., Billing Provider). Please fill in only one below:	
☐	Provider Federal Tax Identification Number: _____
OR	
☐	National Provider Identifier (NPI): _____

I _____, hereby authorize Network Medical Management to

Practice Owner/CEO

provide eSolutions fka ClaimRemedi **with the Electronic Remittance Advice for our organization.**

Authorized Party/Clearing House (***Office Ally or Claim Remedi Only***)

Practice/Owner Name: _____

Practice/Owner Signature: _____ **Date:**_____

Please complete all sections. Incomplete submissions will not be processed.