eSolutions
Strengthen your revenue health

Payer ID: ABLPY

AblePay Health
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).
- **Please note:** EFT Enrollment is required. You must include a voided check or a bank letter **AND** a W-9 with the agreement.
- EDI enrollment processing timeframe is approximately **20 business days**.

835 Electronic Remittance Advice:

AblePay Electronic Remittance Advice and Electronic Funds Transfer (EFT) Authorization Agreement
Complete all sections on Page 1. An asterisk indicates a required field.
Provider or Authorized Individual must print name, title, date and sign where indicated on Page 2.

Submit Completed Document:

Email to eSolutions to complete the enrollment
ESH@esolutionsinc.com

AblePay Health Electronic Remittance Advice and Electronic Funds Transfer (EFT) Authorization Agreement

Asterisk (*) indicates required fields within each section. Incomplete and/or illegible fields and signatures will cause your enrollment to be delayed. Refer to instructions before completing this form.

Provider Information		
*Provider Name:		
*Doing Business As Name (DBA):		
*Street:		
*City:	*State:	*Zip Code:

Provider Identifiers Information										
*Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):										
*National Provider Identification Number (NPI):										
*Trading Partner ID:										
Other Identifier:										

EPIProvider Contact Information	
*Provider Contact Name:	Title:
*Telephone Number: ( ) -	*Fax Number: ( ) -
*E-mail:	

Electronic Remittance Advice Information										
*Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier) (Select One)										
☐ Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):										
☐ National Provider Identification Number (NPI):										

Electronic Remittance Advice Clearinghouse Information	
*Clearinghouse Name:	*Clearinghouse Contact Name:
*Clearinghouse Phone:	*E-mail:

Vendor Information		
*Software Company Name:		
*Software Company Contact Name:		
Software Company Address:		
City:	State:	Zip Code:
*Phone:	Fax:	
E-mail:		

Financial Institution Information		
*Financial Institution Name		
*Current Address:		
*Financial Institution Routing Number:		
*Type of Account at Financial Institution	☐ Checking	☐ Savings
*Provider's Account Number with Financial Institution:		

Submission Information		
*Reason for Submission	☐ New Enrollment	☐ Change Enrollment
*Include with Enrollment Submission	☐ Bank Letter	☐ Voided Check

AblePay
SIMPLE HEALTH SAVINGS

AblePay Health Electronic Remittance Advice and Electronic Funds Transfer (EFT) Authorization Agreement

Asterisk (*) indicates required fields within each section. Incomplete and/or illegible fields and signatures will cause your enrollment to be delayed. Refer to instructions before completing this form.

Authorization Agreement — Electronic Funds Transfers (EFT)	
I hereby authorize AblePay Health, to initiate credit entries to the account at the bank listed above for all benefits payments. This agreement will remain in effect until I notify AblePay Health of the desire to cancel or change this service or until AblePay Health notifies me that this service has been terminated. I understand I must allow reasonable time for my instructions to be executed. I authorize and request the bank listed above to accept any credit entries by AblePay Health to such account and to credit the same to such account. AblePay Health will not debit or deduct funds directly from my bank account for claim overpayments and/or refund requests, but AblePay Health reserves the right to request a refund from Provider for claims submitted and paid erroneously. *AblePay Health adheres to the National Automated Clearing House Association (NACHA) guidelines.	
Authorized Signature *By signing below, I hereby agree that I have read and agree to the terms and conditions stated above. Furthermore, the undersigned certifies that the information provided is true and accurate in all respects and that he/she has been duly authorized by all necessary and appropriate action.*	
*Written Signature of Person Submitting Enrollment	*Printed Name of Person Submitting Enrollment
*Printed Title of Person Submitting Enrollment	*Submission Date

Enrollment Instructions:

1. Please complete one form per Tax ID
2. Attach provider listing that includes:
   - All Provider Names & Titles
   - All Provider Specialties and Taxonomy Codes
   - All Provider NPIs #
3. Include a pre-printed voided check with the account holder name imprinted on the check or a bank letter
4. Include a W9 form
5. Completed enrollment form can be e-mailed to valerie.banotai@ablepayhealth.com

IMPORTANT:
Please allow 15 business days for processing. Processing times may vary depending on number of enrollments received, the accuracy of the information provided and whether the form is legible. We will send confirmation when the ERA and/or EFT will start. To take advantage of direct deposit (EFT), your bank must be participating member of the Automated Clearinghouse Association (ACH). You are responsible for notifying AblePay Health of any changes to your banking information. You may receive a phone call from AblePay Health to ensure the accuracy of banking information.

AblePay Health's ACH Payment Related Information for CCD+ EFT payments include the TRN Reassociation Trace Number in the Addenda record. Provider must contact their banking institution to request this data be available for viewing.

EFT Notification
If you would like to receive an e-mail notification when AblePay Health transmits an EFT to your banking institution, you may supply two clearly printed e-mail address in the space below:

E-mail 1: ____

E-mail 2: ____