

## **ECHO**

### **Electronic Remittance Advice**

### **ERA 835**

#### **ERA Enrollment Instructions:**

- Please save this document to your computer. Open the file and type directly onto the form.
- Complete the form using the provider's **billing/group information as credentialed** with this payer.
- **EDI enrollment applies to ERA only and is not necessary prior to sending claims.**
- Once completed, save for your records, print and obtain appropriate signature(s).
- EDI enrollment processing timeframe is approximately **30-45 business days**.
- To check status of EDI enrollment, please **contact ECHO at 440-835-3511**.

#### **835 Electronic Remittance Advice:**

##### **ECHO ANSI 835 Enrollment Form**

Complete the form as appropriate.

Complete one form per Tax ID to include all 835 payers offered by ECHO.

#### **Submit Completed Document:**

Email to ECHO Healthcare Systems

[edi@echohealthinc.com](mailto:edi@echohealthinc.com)

### 835 Payer List

Access Health Services - Arkansas Superior Select	Employee Benefit Consultants
ACS Benefit Services	Employee Benefit Services, Inc. (EBSI)
Affinity Health Plan	Evolutions Healthcare Systems
Affinity Medicare & Medicaid Advantage	Family Health Network (IL)
AFLAC of Georgia (Am. Family Life Assurance)	FMH Benefit Services - CoreSource
AllCare	Fresenius Medical Care Health Plan
Alliance Coal Health Plan	GemCare – Managed Care Systems
AltaMed	Global Care – Boulder Administration
AMA Insurance (Am. Medical Associates)	G.M.P. – Employers Retiree Trust
AmeraPlan	GMS, Inc.
American Healthcare Alliance	Group Health Inc (GHI) – Emblem Health
American Progressive	Health Cost Solutions
America’s Choice Healthplan	Health Ins. Plan of New York - HIP
AmeriHealth Caritas Delaware	Health Partners - Pennsylvania
AmeriHealth Caritas District of Columbia	Healthcare Highways
AmeriHealth Caritas Louisiana	Healthcare Management Admin. HMA
AmeriHealth Caritas Pennsylvania	HealthChoice Oklahoma, DSR, DOC
AmeriHealth Caritas New Hampshire	HealthSCOPE Benefits
AmeriHealth Caritas Northeast	Healthscope – Community HA
AmeriHealth Caritas VIP Care	HealthSmart – All Plans
AmeriHealth Caritas VIP Care Plus (Michigan	Hoag Clinic (Hoag Physician Partners)
Ameritas Life Insurance Co	HSBS Memphis
AmFirst Insurance Co.	InHealth Mutual of Ohio
Atlantic Coast Life Ins.	Insurance Management Services
Banner Health Co – All plans	INTEGRA Admin. Group
Benefit Plan Administrators	Kalos Gold Health Plan
Boulder Administration Services	Keystone First Community Health Choice
Capitol Administrators	Keystone First Health Plan
Caprock Health Plan	Keystone First VIP Choices
CareMore Health Plans	Liberty Dental Plan, Inc.
CareNCare	Lifestyle Health Plan – Medova Healthcare
CareSource- All States	Managed Care Systems (MCS03)
Catholic Life Insurance – United Financial	Maricopa Health Plan
Central California Alliance for Health (CCAHA)	Marion Health Services - CHW
CHCS Services, Inc.	Marrick Medical Finance
Clear Spring Health	MCA Administrators, Inc.
Coastal TPA Inc.	Meritain Health
Community Care Alliance of Illinois	Michigan Blue Cross Complete
Community Health Choice	Mid-American Benefits, Inc.
ConnectiCare Commercial and Medicare Adv.	Monitor Life Insurance Co. of New York
Constitution Life Insurance Co.	Multiplan WI Preferred Provider Network
Consumers Choice Health	Municipal Health Benefit Plan
CoreSource – All Plans	Mutual Health Services
Corporate Benefit Services of America (CBSA)	Native Care Health
Covenant Administrators, Inc.	Nippon Life Benefits
Custom Design Benefits	North American Administrators, Inc.
Delano Regional Medical Group	Ohio PPO Connect
Diversified Group Administration	One Call Medical
EBC, Inc.	
EBSO Inc. - Expert Benefit Services	





**Form Instructions:**

- 1. For new enrollments only (for changes, contact ECHO at 440.835.3511 ext 106)
- 2. Requires Adobe® Reader® 7.x or greater
- 3. All fields are required, unless otherwise indicated
- 4. Print completed form, sign it, Fax or e-mail (secure recommended) to ECHO Health, Inc.

## ECHO ANSI 835 Enrollment Form

### Healthcare Service Provider

\* Name \_\_\_\_\_

\* Billing Address (number & street) \_\_\_\_\_

\* City \_\_\_\_\_ \* State/Prov ..... Select ..... \* Zipcode \_\_\_\_\_ \* Phone \_\_\_\_\_

\* Tax ID Number

\* Payer Name ALL ECHO 835 ERA PAYERS

\* E-mail address \_\_\_\_\_ E-mail address 2 (optional) \_\_\_\_\_

\* Do you use a clearinghouse?  Yes  No

If "yes," provide clearinghouse name: ClaimRemedi

If "no," provide internal contact name: \_\_\_\_\_

\* I will accept 1099s electronically  Yes  No

If "yes," send to e-mail address shown: \_\_\_\_\_

**Approval by person authorized to sign this document (e.g., Provider Billing Supervisor)**

\* Approved By (print name): \_\_\_\_\_ \* Title \_\_\_\_\_

\* Healthcare Service Provider Name: \_\_\_\_\_

\* Phone \_\_\_\_\_ \* E-mail \_\_\_\_\_ \* Approval Date (mm/dd/yyyy): \_\_\_\_\_

\* Approver signature: \_\_\_\_\_

\* Required field. Must be filled in.

**Print**

**Reset**