Payer ID: 85729

HealthComp
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 provider's **billing/group information as credentialed** with this payer.
- Once completed, save for your records, print and obtain appropriate signature(s).
- ERA setups are generally completed in approximately **15 business days**.
- To check status of EDI enrollment, please contact **HealthComp at 559-499-2450**.

837 Claim Transactions:

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

835 Electronic Remittance Advice:

HealthComp Electronic Remittance Advice (ERA) Authorization Agreement

Complete all pages of the form and letter as appropriate.

Submit Completed Document:

Fax all pages to HealthComp

559-499-2464 or 559-499-2039

HealthComp
Third Party Administrators

Electronic Remittance Advice (ERA) Authorization Agreement

Provider Information

Provider Name _____

Provider Street Address _____

City _____ State _____ Zip _____

Provider Identifier Information

Provider Federal Tax Identification Number (TIN)_____

National Provider Identifier (NPI) _____

Provider Contact Information

Provider Contact Name _____ Title _____

Telephone Number _____ Fax Number _____

Email Address _____

Electronic Remittance Advice Information

Please indicate how you would like your claim payment remittance advices (ERA's) grouped: *

(Choose One)

O by Provider Tax Identification Number (TIN): ☐

O by National Provider Identification Number (NPI): ☐

* ***NOTE***: *This must match the preference selected on your EFT enrollment form.*

Electronic Remittance Advice Clearinghouse Information *

Clearinghouse Name Office Ally

Telephone Number 360-975-7000 Option 1 Email Address Support@officeally.com

** If other than Office Ally, please include the attached authorization letter with your enrollment form.*

Electronic Remittance Advice Vendor Information (if applicable)

Vendor Name ClaimRemedi

Telephone Number 866-633-4726 Email Address Enrollment@esolutionsinc.com

Submission Information

Reason for Submission: **O** New Enrollment **O** Change Enrollment **O** Cancel Enrollment

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Printed Name of Person Submitting Enrollment _____

Authorized Signature _____

Submission Date _____ Requested ERA Effective Date _____

This authorization will remain in effect until an ERA Authorization Agreement form marked as 'cancel enrollment' or 'change enrollment' is submitted to HealthComp. Any changes to the provider's clearinghouse or vendor must be submitted on an ERA Authorization Agreement form. The termination or change shall be effective 20 days after HealthComp's receipt of the updated form.

HealthComp®
Third Party Administrators

Instructions for completing the ERA Registration form

- Please type or print legibly.
- Use only black or blue ink to complete form.
- Please allow 3 weeks for registration process to be completed. If after 4 weeks you do not start receiving ERA's then you may contact HealthComp at 559-499-2450.
- **For questions about this form, please call 559-499-2450**

Provider Information

- **Provider Name:** Please fill out completely.
- **Provider Address:** Complete legal name of institution, corporate entity, practice or individual provider.
- **Street:** The number and street name where a person or organization can be found.
- **City:** City associated with provider address field.
- **State:** Character code associated with the state. 2 digits.
- **Zip Code:** Postal zone code.

Provider Identifier Information

- **Provider Federal Tax Identification Number (TIN):** Federal tax identification number used to identify a business. 9 digits.
- **National Provider Identifier (NPI):** HIPAA unique provider identifier. 10 digits.

Provider Contact Information

- **Provider Contact Information:** Enter the name of the person, title, phone/fax number and e-mail address of the person authorized to provide information that relates to electronic remittance advices.

Electronic Remittance Advice Information

- **Preference for Grouping of Remittance Data:** This must match the preference on the EFT enrollment form. Select one option and provide the number:

  - **By Provider Tax Identification Number (TIN):** Federal tax identification number (TIN). Numeric, 9 digits
  - **By National Provider Identifier (NPI):** Unique identification number for covered healthcare providers. Numeric, 10 digits

Clearinghouse Information

- **Clearinghouse Name:** Official name of the provider's clearinghouse.
- **Telephone Number:** Telephone number for clearinghouse contact.
- **Email Address:** Email address for clearinghouse contact.

Vendor Information (if applicable)

- **Vendor Name:** Official name of the provider's vendor.
- **Telephone Number:** Telephone number for vendor contact.
- **Email Address:** Email address for vendor contact.

Submission Information:

- **New Enrollment:** Enrollment of new ERA account.
- **Change Enrollment:** This information facilitates the registration transition from an old to a new clearinghouse and expedites processing your change.
- **Cancel Enrollment:** Use to terminate receipt of electronic remittance advice data.

- **Printed Name of Person Submitting Enrollment:** Printed name of preparer or responsible individual.
- **Authorized Signature:** Signature of preparer or responsible individual.
- **Submission Date:** Enter the date submitted for enrollment.
- **Requested ERA Effective Date:** This is the date the provider wishes to begin receiving ERA data.

Fax the completed form to: 1-559-499-2464

IMPORTANT: HealthComp uses a clearinghouse named Office Ally to deliver provider ERA's. If you will be using a clearinghouse OTHER THAN Office Ally to receive ERA's, please provide the following information and include it with your HealthComp ERA enrollment form. This letter will authorize Office Ally to direct your electronic remittance advices to the clearinghouse indicated on your HealthComp ERA enrollment form. Fax the completed ERA enrollment form and this Office Ally authorization letter to 559-499-2464.

PRINT ON PROVIDER LETTERHEAD

ENTER DATE

Office Ally, LLC
Fax: 360-896-2151

RE: ERA Linking Letter

To Whom It May Concern:

I hereby authorize Office Ally to link any and all of Enter Provider/Group Name's 835/ERA transactions for the Tax ID(s) and NPI(s) listed below to account/username: ClaimRemedi.

Tax ID(s): _____

NPI(s): _____

Please move all ERAs over to this new account as of: **XX/XX/XXXX [Enter Date]**

I certify that I am an authorized individual for the Tax ID(s) and NPI(s) listed above.

Thank you,

[Authorized Signature] – Owner of Practice/Provider/CEO/CFO/ COO

[Printed Name AND Title]