Payer ID: IP079

Mercy Physicians Medical Group
(NAMM Southern CA)
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).
- Signature on the ERA Transfer Letter must be handwritten. Electronic signatures will be rejected.
- EDI enrollment processing timeframe is approximately **5-7 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.

ERA Transfer Letter (must be completed on company letterhead)
Complete the form as appropriate.
Print the template onto company letterhead and sign, print name, and print title where indicated.

PLEASE NOTE: The title of the signer ***must*** be Owner, Co-Owner, CEO, CIO, CFO, COO, President, Vice President, Director, Executive Director, Interim Director, Provost or Administrator. **The enrollment will be rejected if the title of the signer is not of one of these listed.**

Submit Completed Documents:

1. **Email or Fax ERA Form** to NAMM EDI Operations
   EDIOperations@nammcal.com
   866-596-7210

2. **Fax the ERA Transfer Letter** to Officeally
   360- 896-2151

Electronic Remittance Advice (ERA) Enrollment Form

Return Completed Forms to:
Email:
EDIOperations@nammcal.com
Fax: (866) 596-7210
Mail: EDI Department
3990 Concours, Suite 500
Ontario, CA. 91764

Please PRINT clearly

Please note: Upon enrollment processing, Provider will receive both Paper Explanation of Payment and Electronic Remittance Advice (ERA) for 31 calendar days, after which time provider will receive ERA.

Provider Information (REQUIRED)

Provider Name:		
Provider Address Street:		
City:	State/Province:	Zip Code/Postal Code:

Provider Identifiers (REQUIRED)

Provider Federal Tax Identification Number (TIN) or Employer Identification Number:	
National Provider Identifier (NPI):	

Provider Contact Information

Provider Contact Name:		Title:
Telephone Number:	Telephone Number Extension:	Email Address:

Electronic Remittance Advice Information (REQUIRED)

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)
SELECT ONE

☐ Provider Tax Identification Number (TIN) ☐ National Provider Identifier (NPI)

Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name: Office Ally

Submission Information

Reason for Submission: ☐ NEW Enrollment ☐ CHANGE Enrollment ☐ CANCEL Enrollment

The undersigned hereby certifies that the information provided herein is true and accurate in all respects and that he/she has been duly authorized by all necessary and appropriate corporation action, where applicable, to execute this agreement on behalf of the above mentioned Provider Name to form a legally binding contract. The undersigned authorizes Mercy Physicians Medical Group, Inc. (herein referred to as "MPMG") to transmit electronic remittance advice (ERA) detail for claims processed by MPMG to the provider listed above. In addition, the undersigned hereby agrees that upon completion of enrollment processing, MPMG will concurrently send paper explanation of payment and ERA for a period of 31 calendar days, after which time provider will only receive ERA.
This Authorization is to remain in full force and effect until MPMG has received written notification of its termination in such time and manner as to afford MPMG a reasonable opportunity to act on it.

Authorized Signature:_____ Date:_____

Printed Name of Person Submitting Enrollment

RE: ERA Transfer Letter *(Must be printed on Provider/Group/Company/Practice Letterhead)*

To Whom It May Concern:

I hereby authorize Office Ally to link any and all 835s/ERAs for the **Provider/Group** listed below, having the **Tax ID** and/or **NPI** below, to the **Username/Clearinghouse** listed below:

Provider/Group Name: _____

Tax ID: _____

NPI: _____

ERAs to be linked to: ClaimRemedi

(***MUST BE ADMIN/PARENT USERNAME, NOT SA ACCOUNT)***

Email Address: enrollment@claimremedi.com

(List email address for confirmation of approval+transfer or denial)

Please move all ERAs over to this new account as of this date: _____

NOTE: *If you want us to transfer old ERAs to the new username, please list the date to go back to above.*

By signing below, I certify that I am an authorized individual for the Provider/Group, Tax ID(s) and NPI(s) listed above and that I am authorized to sign on their behalf.

_____

Authorized Individual's Signature

_____

Printed Name of Authorized Individual

Title of Authorized Individual (circle one): **Owner, Co-Owner, CEO, CIO, CFO, COO, President, Vice President, Director, Executive Director, Interim Director, Provost or Administrator.**

Please note: the main reasons for denial is lack of letterhead, a missing or lack of *HAND WRITTEN* signature and an invalid title of authorized individual. Please be aware of this to prevent denial of transfer letter.