Payer ID: SFHP1

# San Francisco Health Plan
# 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.
- EDI enrollment processing timeframe is approximately **10-15 business days**.

**835 Electronic Remittance Advice:**

**Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Enrollment Form**
Complete all applicable fields.
Select preference for Data Aggregation by checking the appropriate box.
Choose a Reason for Submission by checking the appropriate box.
Provider or Authorized Person must sign and print name where indicated at the bottom of the form.
If enrolling for EFT, complete Box B and include a copy of a voided check.

**Submit Completed Document:**

**E-mail** all pages to eSolutions with this cover sheet.
The enrollment specialist will complete the setup with the payer.
ESH@claimremedi.com

SAN FRANCISCO HEALTH PLAN
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# Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) enrollment

## Instructions

San Francisco Health Plan offers Electronic Funds Transfer (EFT) for claim payments to a contracted provider's bank account. In order to participate in EFT, your financial institution must be a participating member of the Automated Clearinghouse Association (ACH).

You must contact your financial institution to arrange for the delivery of reassociation information via the ACH Cash Concentration or Disbursement plus addenda record (CCD+). It is the provider's responsibility to notify SFHP of any changes to your banking information.

Please allow 10-15 business days for processing. Processing times may vary.

To enroll for EFT or ERA, please complete the following steps:

1. Complete the form
    - Always complete Box A (Provider Information). If you want to enroll in EFT, complete Box B (Financial Institution Information). If you want to enroll in ERA, complete Box C (ERA Information)
    - Enter information for all required fields marked with an asterisk (*). Incomplete and/or illegible fields and signatures will cause your enrollment to be delayed.
    - Include contact information so SFHP can contact the correct person with any questions about the form.
    - Multiple National Provider Identifiers (NPIs) can be entered for the same bank account.
    - Complete a separate authorization form for each bank account.
2. If enrolling in EFT (Box B), attach a Copy of a Voided Check
    - An account verification letter on bank letterhead is also acceptable.
    - SFHP needs this information to verify the provider's bank name and routing number.
3. **Email the Form and Copy of a Voided Check to EFT_835_Intake@sfhp.org**

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# Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

## Enrollment Form

| **Box A: Provider Information** | |
|---|---|
| *Provider name: | |
| *Street address: | |
| *City, State, and ZIP/Postal code: | |
| Telephone number: | Email: |
| *Provider Federal Tax ID Number (TIN) or Employer ID Number (EIN): | |
| *National Provider Identifier(s) [NPI(s)]: | |
| *Provider Contact Person: | Title: |
| *Telephone number: | Fax Number: |
| *Email address: | |

| **Box B: Financial Institution Information** | |
|---|---|
| *Financial Institution Name: | *Telephone: |
| *Street: | |
| *City, State, and ZIP/Postal code: | |
| *Financial Institution Routing Number: | |
| *Type of Account and Number: ☐ Checking ☐ Savings | |
| *Account number Linkage to Provider Identifier: ☐ TIN/EIN ☐ NPI(s) | |
| *Reason for Submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment | |
| *Included with Enrollment (must provide at least one): ☐ Voided Check ☐ Bank Letter | |
| *Name of Authorized Official: | |
| *Signature of Authorized Official: | |

| **Box C: ERA Information** | |
|---|---|
| *Preference for Aggregation of Remittance Data (select one): ☐ TIN/EIN ☐ NPI | |
| Clearinghouse Name: Zirmed | Clearinghouse Contact Name: Enrollment Department |
| Telephone Number: 877-494-7633 | Email: Enrollment@zirmed.com |
| Vendor Name: | Vendor Contact Name: |
| Telephone Number: | Email: |
| *Reason for Submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment | |
| *Name of Authorized Official: | |
| *Signature of Authorized Official: | |