Payer ID: EXC01

Physicians Medical Group of San Jose
Excel MSO
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 **Excel MSO at Providerservices@excelmso.com** .

837 Claim Transactions:

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

835 Electronic Remittance Advice:

PMGSJ / Excel MSO 835 Enrollment Request

Complete the form as appropriate.

ERA Linkage Form

Complete the form as appropriate.
Enter an Effective Date for the enrollment under the 'Receiver Information' section.

Submit Completed Document to both:

1. **Email or Fax BOTH forms** to Excel MSO
   Providerservices@excelmso.com
   408-937-3639

2. **Email the ERA Linkage Form to** Office Ally
   ERALinkage@OfficeAlly.com

PMGSJ / EXCEL MSO (EXC01)
835 ENROLLMENT REQUEST

Email this form to Providerservices@excelmso.com or Fax to (408) 937-3639. Please make sure to print legibly and to complete this form in its entirety. You risk delaying enrollment if the application is unreadable or incomplete.

PROVIDER INFORMATION:

Provider Name:

Provider Address: **City:** **State:** **Zip:**

PROVIDER IDENTIFIER INFORMATION:

Provider Federal Tax Identification Number (TIN) OR Employer Identification Number (EIN):

National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION:

Provider Contact Name: **Telephone Number/Ext:**

Email Address: Fax Number:

ELECTRONIC REMITTANCE ADVICE INFORMATION:

Preference for Aggregation of Remittance Data: (i.e. Account Number Linkage to Provider Identifier). Provider preference for grouping (bulking) claim payment advice must match preference for EFT payment (i.e. Billing Provider). Choose only one.

☐ Provider Federal Tax Idenitification Number (TIN):

☐ National Provider Identifier (NPI):

SUBMISSION INFORMATION:

Reason for Submission: New ERA Enrollment

Authorized Signature:

Note: *Electronic Signature (typed name) of Person Submitting ERA Enrollment.*

Office Ally

ERA LINKAGE FORM

Payer ID: EXC01

Payer Name: Excel MSO (PMG of San Jose)

PROVIDER INFORMATION

Provider Name:

Provider Tax ID:

Provider NPI:

Provider Contact Name:

Provider Contact Email:

Provider Contact Phone:

RECEIVER INFORMATION

OA Username: claimremedi

Clearinghouse Name: ClaimRemedi

Effective Date:

Note: Effective Date may not be more than two weeks prior to the submission date of this form.

FORM SUBMISSION INSTRUCTIONS

For ERA Enrollment forms sent to Office Ally: Submit the ERA Linkage Form with the ERA Enrollment form.

For ERA Enrollment Forms NOT sent to Office Ally or for payers without ERA Enrollment: Submit the ERA Linkage Form to **ERALinkage@OfficeAlly.com**.