Electronic Remittance Advice (ERA) Enrollment Form

ENROLLMENT

New Enrollment ☐ **Change Enrollment** ☐ **Cancel Enrollment** ☐

Requested ERA Effective Date: _____

PROVIDER INFORMATION

Provider Name: _____

Doing Business As (DBA) Name: _____

Payee Name: _____

Tax Identification Number: _____

National Provider Identifier: _____

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier): **Tax ID:** ☐ **NPI:** ☐

BILLING OFFICE CONTACT INFORMATION (if different from Provider)

EFT Contact Name: _____

EFT Contact Phone #: _____

EFT Contact Email: _____

Technical Contact Name: _____

Technical Contact Phone # : _____

Technical Contact Email: _____

TRADING PARTNER AND SOFTWARE VENDOR INFORMATION (for ERA Enrollment)

If you send and receive electronic files through a clearinghouse (e.g. Office Ally, Healthsmart), please place their name below and your associated Submitter ID.

Clearinghouse Name: _____

Clearinghouse Submitter ID: _____

Software Vendor Name: _____

AUTHORIZATION AGREEMENT

Authorized Signature : _____ **Date:** _____

Printed Name: _____

Please return this form to Heraya Health

FAX: 877-482-2856 OR MAIL: Heraya Health, PO Box 278, Beaverton, OR 97075-0278

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