
CareSource Ohio - (31114) Enrollment Instructions – ERA only

- ✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record added.** Please contact your EDI solutions reseller to confirm EDI customer account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck to make sure provider ID #s are valid. Invalid or incorrect provider IDs will cause the enrollment to be delayed or rejected.
- ✓ **Make a copy of the completed enrollment pages.** Note the date and method of submission. Keep a copy of the submitted paperwork, in case you need to follow up on your request.

FAX COMPLETED FORMS TO-
InstaMed, 1-877-755-3392

835- ERAs Electronic Remittance Request (New) or (Change of Service)

If the provider wishes to authorize Practice Insight to retrieve 835 ERA files, the provider must complete this form:

1. The InstaMed Network Electronic Funds Transfer Enrollment Form (2 pages)

Page 1

Section One - General Information

Enter Billing Provider Information and Contact Information.

Enter Tax ID # associated to Billing Provider.

Section Two – Remittance File Delivery

If this is a request to CHANGE existing ERA setup- add this notation :

CHANGE TO EXISTING ERA ENROLLMENT

Page 2

Section Three – Electronic Funds Transfer

Enter EFT Information. EFT is required to receive CareSource ERAs.

Attach voided check or a photocopy of a voided check.

Authorized Signature required (see bottom of page).

2. The billing provider must complete and fax the Practice Insight ERA Request Form.

ALLOW 2-4 WEEKS FOR PROCESSING

If it has been over 30 days since request was submitted and ERAs are not being received, providers should contact their EDI support representative or reseller. Resellers may contact Practice Insight, Enrollment Department for assistance.

The InstaMed Network Electronic Funds Transfer Enrollment Form

Please complete this form to enroll in both the InstaMed Provider Portal to view electronic remittances (ERA) and to enroll in Electronic Funds Transfer (EFT). Please return the completed form along with a voided check to enroll in Electronic Funds Transfer, via fax or mail to:

FAX: (877) 755-3392

MAIL: InstaMed
P.O. Box 58790
Philadelphia, PA 19102

QUESTIONS? (215) 789-3682

NOTE: By enrolling in EFT/ERA, you agree that you will NO LONGER receive a paper check or paper Explanation of Payment. These are available on the Provider Portal.

SECTION ONE – GENERAL INFORMATION

Provider Information *(all information is required unless otherwise noted)*

If you want to enroll more than one provider, please list additional names, NPIs and Tax IDs on a separate sheet and submit.

<u>Practice Administrator Contact Information</u>			
Provider Name			
Practice Name		Name	
Address		Phone	
City	State	Zip	Email
Practice/Provider Billing NPI <i>(if available)</i>		Fax	

Practice/Provider Tax IDs

Please provide your billing Tax ID(s) for the above named provider and, if populated, practice name. Tax ID is required for account setup.

Tax ID: _____ Tax ID: _____ Tax ID: _____ Tax ID: _____

EIN SSN

EIN SSN

EIN SSN

EIN SSN

SECTION TWO – REMITTANCE FILE DELIVERY

Please select your options to receive Electronic Remittance Advice (ERA):

- Receive ERA through InstaMed secure Provider Portal only
- Receive ERA via Secure File Transfer Protocol (SFTP)
- Receive ERA via existing Clearinghouse
Clearinghouse Name: _____

SECTION THREE – ELECTRONIC FUNDS TRANSFER

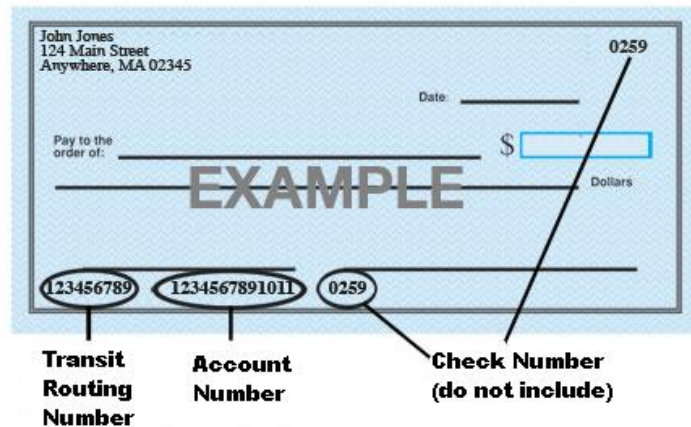
Complete the following information and attach a voided check or photocopy of a voided check. One form is required per bank account. You should begin to receive electronic reimbursement on behalf of CareSource after your successful enrollment is processed.

Settlement Information

Bank Name	Bank Address
Transit Routing Number (TRN)	City State Zip
Account Number	Account Type: <input type="checkbox"/> Savings <input type="checkbox"/> Checking

IMPORTANT: Please attach voided check or a photocopy of a voided check:

<attach voided check here>



Authorization

The undersigned authorizes InstaMed Communications, LLC D.B.A InstaMed to make electronic debits, payments and adjusting entries to the bank account at the depository financial institution (depository) named above for services performed under the network participation agreement between the organization identified above and InstaMed and its affiliates. Such debits, payments and entries shall be made through the regional automated clearinghouse (ACH) associations, subject to the operating rules of the National Automated Clearinghouse Association. This authorization is to remain in full force and effect until InstaMed has received written notice of its termination, allowing us reasonable opportunity to act on it, but in no event later than thirty (30) days advance notice. Revocation will not apply to transactions initiated before the effective date of such revocation. Although no fees are currently charged for this service, in the event InstaMed elects to impose fees, we will notify you in advance. If you do not terminate this authorization after such notice, you authorize InstaMed to deduct such fees from the transfers of funds owed to you under the network participation agreement to the depository specified above. InstaMed may cease providing any or all of these services upon notice to the Primary Contact named above. The undersigned certifies that the above information is true and accurate in all respects and that the undersigned has the authority to initiate the actions requested herein and will promptly notify InstaMed of any changes to the information on this form in writing. InstaMed reserves the right, in its sole discretion, to provide the information regarding the undersigned provided in this form, and the undersigned hereby consents to the provision of such information by InstaMed, to CareSource, Inc. and/or its affiliates, provided that (i) the undersigned has not requested in writing that InstaMed not disclose such information to CareSource, Inc. and/or its affiliates, and (ii) that any such disclosure is otherwise permitted under all applicable legal and regulatory requirements and healthcare and payment industry security standards related to the collection, retention and use of such information.

Authorized Signature Required

Printed Name

Signature

Title

Date