Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms
4/13/2012 (IE,NF)

Ucare Minnesota (52629)
Via Availity
Enrollment Instructions – Professional ERA

- ✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record added.** Please contact your EDI solutions reseller to confirm your EDI account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck provider numbers to be sure they are valid and accurate. 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 completed request in case you should need to follow up on, or resubmit your request.

FAX COMPLETED ERA FORM TO-
Availity, 972-383-6450

MAIL COMPLETED PROVIDER ELECTION FORM TO-
UCare
Attn: Accounting/PPE Dept.
P.O. Box 52
Minneapolis, MN 55440-0052

837– CLAIMS Provider Enrollment (New) or (Change of Service)

No EDI enrollment required to submit electronic claims.

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

1. Multi-Payer Electronic Remittance Advice Enrollment Form (1 page)
   List the Payers with which to Enroll -
   Enter Ucare Minnesota 52629
   Enter Provider Information -
   Enter Organization Name, Tax ID, NPI, etc.
   Signature Required.

2. Provider Payment /Remittance Advice Election Form

Part A – Select Enrollment Type; New Applicant, Change of Clearinghouse, etc. Enter Billing Provider information.
Part B – Enter Contact Information.
Part C – Enter Tax Identification Info.
Part D – Include all of the facility number(s) that will be included in this election.
Part E – Enter EFT Information.
Part F – Provider Signature Required.

ALLOW 2-4 WEEKS FOR PROCESSING

If it has been over 30 days since this request was submitted and you have not yet received confirmation of enrollment, contact your Support Vendor. PI Resellers or Support Vendors may contact the Practice Insight Enrollment Department.

Rev 02.27.2012.1

Multi-Payer Electronic Remittance Advice Enrollment Form

Add or change ERA account: Create New ERA Account

LIST THE PAYERS WITH WHICH TO ENROLL (print or type)	**For payer IDs refer to Availity Health Plan Partner List**
Payer Name	Payer ID
Payer Name	Payer ID
Payer Name	Payer ID
Payer Name	Payer ID
Payer Name	Payer ID

Who will receive the ERA files? Clearinghouse **If Other, please specify:**

ENTER RECEIVER INFORMATION (print or type)					
Availity Customer ID**	Gen Key #13797 Sender ID: H4895				
Receiver Name	Practice Insight, LLC				
Receiver Address	1 Greenway Plaza, Suite 350				
City	Houston	State	TX	ZIP	77046
Contact Name	Enrollment Department	Phone	(713) 333-6000	Extension	2
E-mail Address	enrollment@practiceinsight.net	Fax	(713) 333-0138		

To locate your Availity customer ID, click **Who controls my access? at the top of the Availity portal.

ENTER PROVIDER INFORMATION (print or type)		
Provider Organization Name		
Provider Tax ID	Provider NPI (if applicable)	
Provider Mailing Address		
City	State	ZIP
Authorized Name**	Phone	Extension
E-mail Address	Fax	
Authorized Signature**		Date

****Important Note:** The name and signature provided must be that of an individual who is authorized to sign documents for the practice requesting this 835 enrollment.

If you have any questions about your enrollment, contact Availity Client Services at 1.800.AVAILITY (282.4548). Return this completed, signed form via mail or fax to:

Availity, LLC
P.O. Box 833905
Richardson, TX 75098-3905
(FAX) 972.383.6450

UCare Provider Payment/Remittance Advice Election Form

A. BUSINESS MAILING ADDRESS (GENERAL)

(Name must match Tax ID Number [TIN] records. Only one TIN per form.)

Please check all the boxes that applies for changes/updates or check the "New Applicant" box if this is your first time submitting the form to UCare. Then complete all of the fields.

☑ New Applicant ☐ Change of Bank Information/Payment Method ☐ Change of Clearinghouse ☐ Other Changes/Updates

Name ______________________________

Address ______________________________

City ______________ State ________ Zip Code ☐☐☐☐☐ - ☐☐☐☐

B. BUSINESS CONTACT INFORMATION

Contact Name ______________________________

E-mail Address ______________________________

Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐ Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐

C. TAX IDENTIFICATION NUMBER

Note: *Enter Federal ID name exactly as shown on your SS-4 (Corporate) or Social Security Card (Individual).*

Federal ID Name ______________________________

Federal Tax ID # ☐☐☐☐☐☐☐☐☐

D. FACILITY'S LEGACY OR NPI NUMBER(S)

Note: *Include all of the facility number(s) that will be included in this election.*

________ ________ ________ ________

________ ________ ________ ________

E. PAYMENT METHOD

☐ **Paper Check** ☐ **Electronic Funds Transfer (EFT)**

Note: *If electing EFT, complete the banking information below and attach a voided check. Attaching a voided check to this form is a requirement for EFT.*

Financial Institution Information

NOTE: Do not use '|,' '\,' ',' or '~' in any fields in this section.*

ABA Routing # ☐☐☐☐ - ☐☐☐☐ - ☐

Customer's Acct. # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Type of Account: ☐ Checking ☐ Savings

Financial Institution Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

F. REMITTANCE ADVICE (RA) METHOD - You must choose one of the following methods to receive your RA:

1. **Clearinghouse** - Please indicate the name of the clearinghouse that you are registered with for receiving 835s by checking off one of the boxes below. ***NOTE: You must register with a clearinghouse to receive 835s before UCare can send 835s to your clearinghouse and before you complete and submit this form.***

☑ Availity	☐ eProvider Solutions	☐ RelayHealth
☐ ClaimLynx	☐ GE Healthcare	☐ Rycan Technologies
☐ Cortex EDI	☐ Infotech Global Inc., aka MN e-Connect	☐ SSI Group
☐ Emdeon	☐ PNC Bank	☐ ZirMed

2. **UCare Provider Portal**

☐ Provider Portal ***NOTE: You will not receive an 835 or paper RA if you choose the UCare Provider Portal. RAs will be available online for retrieval only at www.ucare.org/providers/pages/providerportal.aspx.***

3. **Paper RA**

☐ Paper RA ***NOTE: Not available for MINNESOTA providers.***

Authorized Signature (**MUST** be signer on applicable bank account.)	Title
Print Name	Date