Instructions for Completing the Paper Electronic Remittance Advice (ERA) Enrollment Application

General Instructions for completing the Paper ERA Enrollment Application:

- Please type or print legibly
- Complete all fields – **Incomplete applications will not be processed**
- Use only black or blue ink to complete the application
- Please allow four (4) weeks for enrollment application to process. If after five (5) weeks you do not start receiving ERA files, please contact the Provider Assistance Center (PAC) at 1-800-248-2152.

Mail completed enrollment form to:

BDCM PAMMIS
ERA Enrollment, MS 2-400
1250 Camp Hill Bypass, Suite 100
Camp Hill, PA 17011-3700

The electronic ERA enrollment application can be completed by going to the PA PROMIS*e*™ Internet Portal at https://promise.dpw.state.pa.us. On the Login page click the EFT/ ERA Enrollment tab.

Provider Information:

Provider Name: Please provide the complete legal name of the institution, corporate entity, practice, or individual provider.

Provider Address:

Street: Please provide the provider's payment address.

City: Please provide the provider's city associated with the payment address.

State: Please provide the two (2) character code associated with the state name.

Zip Code/Postal Code: Please provide the five (5) or nine (9) digit assigned zip code from the Post Office.

Provider Identifiers:

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): Please provide the nine (9) digit federally assigned Provider Identification number used to identify and track an individual, corporation, partnership, and any other non-business entity.

National Provider Identifier (NPI): Please provide the federally assigned ten (10) digit number for covered Health Care Providers.

Other Identifiers:

Assigning Authority: PA PROMIS*e*™: Pennsylvania Medicaid.

Trading Partner ID: Please provide the assigned thirteen (13) digit Medical Assistance Identification Number. Multiple locations may be included on a single enrollment form. For larger entities please attach a separate sheet listing all locations to be set up.

Example: Provider Number	Service Location	Service Location	Service Location	Service Location
0001112220001	0002	0003	0004	0005

Assigning Authority: PA PROMIS*e*™ EDI Unit

Trading Partner ID: Also known as the submitter ID. This represents the unique nine (9) digit ID number used to access the bulletin board system. With the unique submitter ID Clearinghouse's and additional entities may retrieve remittance advices electronically with the Pennsylvania Medicaid bulletin board system.

Provider Contact Information:

Provider Contact Name: Please provide the name of the provider contact for any ERA issues.

Telephone Number: Please provide the telephone number including area code and if applicable extension number of the provider contact.

Email Address: Please provide the electronic mailing address to send the provider contact correspondence.

Electronic Remittance Advice Information: Please select the provider's preference for aggregation of remittance data and specify the Provider Tax Identification Number (TIN) OR the National Provider Identifier (NPI). This data is information only. Please note that PROMIS*e* does **NOT** group (bulk) payments. Failure to provide aggregation data will NOT delay application processing.

Method of Retrieval: Please select the method by which the provider will receive the ERA from the Health plan.

Electronic Remittance Advice Clearinghouse Information: (If Applicable)

Clearinghouse Name: Please provide the official name of the provider's Clearinghouse.

Clearinghouse Contact Name: Please provide the name of the Clearinghouse contact.

Telephone Number: Please provide the telephone number of the Clearinghouse contact.

Email Address: Please provide the electronic mail address which the health plan may use to contact the provider's Clearinghouse.

Submission Information:

Reason for Submission: Please select one from the list. New Enrollment will allow the provider to enroll for ERA. Change Enrollment will allow the provider to change an existing ERA. Cancel Enrollment will allow the provider to permanently terminate the ERA.

Authorized Signature: This is the signature of the individual authorized by the provider or their agent to initiate, modify, or terminate an ERA enrollment.

Written Signature: This would be a rendering signature (usually cursive) of a name unique to a particular person used as confirmation of authorization and identity.

Printed Name of Person Submitting Enrollment: This is the printed name of the person signing this form who is authorized by the provider or their agent to initiate, modify, or terminate an ERA enrollment.

Printed Title of Person Submitting Enrollment: This is the printed title of the person signing this form who is authorized by the provider or their agent to initiate, modify, or terminate an ERA enrollment.

Submission Date: The date on which the ERA enrollment is submitted.

Requested ERA Start/Change/Cancel Date: The date on which the requested action is to begin.

For questions about this form, please call the Provider Assistance Center (PAC) at 1-800-248-2152 or send an email to ra-835-era@pa.gov.

Missing/Late ERA Files: If you have not received your ERA within four (4) business days of your EFT issuance, please contact the Provider Assistance Center (PAC) at 1-800-248-2152. Requests for files older than 60 days will not be honored.

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pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Electronic Remittance Advice (ERA) Enrollment Application

Provider Information

Provider Name _____

Provider Address

Street _____

(Payment Address)

City _____

State/Province _____ ZIP Code/Postal Code _____

Provider Identifiers

Provider Identifiers

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) _____

National Provider Identifier (NPI) _____

Other Identifier

Assigning Authority **PA PROMISe™**

Trading Partner ID _____ _____ _____ _____

(13-digit Provider ID, plus any additional 4-digit Service Locations)

Assigning Authority **PA PROMISe™ EDI Unit**

Trading Partner ID _____

(9-digit Submitter ID for ANSI X12 v5010 Transactions)

Provider Contact Information

Provider Contact Name _____

Telephone Number _____ Telephone Number Extension _____

Email Address _____

Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)

(Specify either TIN or NPI. Preference will not change aggregation by PROMISe™.)

____ Provider Tax Identification Number (TIN): _____

____National Provider Identifier (NPI): _____

Method of Retrieval

____Clearinghouse

____PA PROMISe Provider Electronic System (PES)

____Other *(please describe)* _____

Electronic Remittance Advice Clearinghouse Information ***(If applicable)***

Clearinghouse Name_____

Clearinghouse Contact Name_____

Telephone Number_____

Email Address _____

Submission Information

Reason for Submission ***(Choose one)***

____New Enrollment

____Change Enrollment

____Cancel Enrollment

NOTE: Providers enrolled for 835/ERA are not eligible to receive Paper Remittance Advice by mail.

Authorized Signature

_____

Written Signature of Person Submitting Enrollment

_____

Printed Name of Person Submitting Enrollment

_____

Printed Title of Person Submitting Enrollment

Submission Date_____ *(format: CCYYMMDD)*

Mail completed enrollment form to:

BDCM PAMMIS
ERA Enrollment, MS 2-400
1250 Camp Hill Bypass, Suite 100
Camp Hill, PA 17011-3700