UCare Minnesota (52629)

Enrollment Instructions - Professional ERA Only

✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record(s) added.** Please contact your EDI solutions reseller to confirm your EDI account setup.

EMAIL OR FAX to- Availity
Email: Autoreg835@availity.com (preferred method)
Fax: 904-470-4773

835–ERAs Electronic Remittance Advice NEW or CHANGE OF SERVICE

1. Availity Electronic Remittance Advice Enrollment Form (1 page)

SEE "**Enter Provider Information**"
Enter the Billing Provider GROUP information, or info of individual provider if billing solo.
Organization (Group) Name, Billing Provider Tax ID #, Group NPI #

SEE "**Contact Information**" Provider Identifiers Information
Enter contact person at provider's office- Name, ***Telephone Number***, ***Email Address***

SEE "**Electronic Remittance Advice Information**"
Put ✓ and **Enter TAX ID** next to ***Provider Tax Identification Number*** (ERA setup entirely on Tax ID #)
-OR-
Put ✓ and **Enter NPI** next to ***National Provider Identifier*** (ERA setup based on NPI # only.)

SEE "**Submission Information**"
Put ✓ next to ***New Enrollment*** (if this is first-time request for ERA setup for this provider)
Put ✓ next to ***Change Enrollment*** (if this request is to change the ERA setup for this provider.)

Obtain "***Authorized Signature***" (To ensure that this request is accepted it is best to obtain signature from the lead physician (provider) or one of the provider's under this billing group.)
Enter ***Printed Name of Person Submitting Enrollment*** (Should be same name as Signer.)
Enter ***Submission Date***

ALLOW 2-4 WEEKS FOR PROCESSING

*If you do not begin receiving ERAs within 30 business days after the request has been submitted, contact your support vendor for assistance.
Practice Insight Resellers or Support Vendors may contact Practice Insight Enrollment Department direct to check on status of enrollment.*

Multi-Payer
Electronic Remittance Advice Enrollment

Rev. 03.04.2014.1

PAYER INFORMATION	Refer to the Availity Health Plan Partner List for payer IDs.
Payer Name:	Payer ID:
Payer Name:	Payer ID:
Payer Name:	Payer ID:
Payer Name:	Payer ID:
Payer Name:	Payer ID:

RECEIVER INFORMATION				* If different than provider contact information.
Who will receive your ERA files?	☐ Provider	☐ Clearinghouse	☐ Vendor	
Receiver Name:			Availity Customer ID:	
Contact Name*:				
Telephone Number*:	Ext:	E-mail Address*:		

PROVIDER INFORMATION			PROVIDER IDENTIFIERS INFORMATION
Provider Name:			Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):
Street:			
City:	State/Province:	ZIP Code/Postal Code:	National Provider Identifier (NPI):
Provider Name:			Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):
Street:			
City:	State/Province:	ZIP Code/Postal Code:	National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION	
Provider Contact Name:	
Telephone Number:	E-mail Address:

ELECTRONIC REMITTANCE ADVICE INFORMATION	
Preference for Aggregation of Remittance Data	☐ Provider Tax Identification Number (TIN):
	☐ National Provider Identifier (NPI):

SUBMISSION INFORMATION			
Reason for Submission:	☐ New Enrollment	☐ Change Enrollment	☐ Cancel Enrollment

Authorized Signature:

Important: By typing or signing a name in this field, you acknowledge and agree that you have been authorized by the provider or its agent to initiate, modify, or terminate an enrollment. You further acknowledge and agree that you have the legal authority to perform such action on behalf of your organization. In no event will Availity be liable for any losses or damages including without limitation, indirect or consequential losses or damages, or any loss or damage whatsoever arising from loss of data or profits arising out of, or in connection with this submission.

Printed Name of Person Submitting Enrollment:	Submission Date:

SEND THE FORM VIA:	E-mail:	Fax: 904.470.4773	Mail: Avality LLC P.O. Box 550857 Jacksonville, FL 32255-0857

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