Capario℠
Connectivity. Solutions. Insight.

PAYER ENROLLMENT INSTRUCTIONS FOR

STEP 1: COMPLETE AGREEMENT

- Complete all required fields on agreement and verify that information entered is correct.
- If an agreement requires signatures, we recommend signing in **blue ink**. Do not use signature stamps.

STEP 2: PROCESS

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STEP 3: COMPLETE CAPARIO ENROLLMENT SPREADSHEETS

- **Capario Provider Spreadsheet** – This is completed for each new provider.
  http://www.capario.com/downloads/xls/provider_bulk_spreadsheet.xlsx

- **Capario Payer Enrollment Spreadsheet** – This is completed when requesting enrollment with a payer for providers previously added to the Capario system. Please refer to the instruction tab on each spreadsheet form for details about the information to enter in each column.
  PLEASE NOTE The fields for tracking information are key for both your record keeping of enrollments and for Capario following up with payers for approvals. Be sure to enter all tracking for each enrollment.
  http://www.capario.com/downloads/xls/enrollment_bulk_spreadsheet.xlsx

Email the completed spreadsheet(s) to: provider.enrollment@capario.com

Questions? Contact us:

Phone: (800) 792-5256 Option 1 **Fax:** (404) 877- 3324 **Email:** provider.enrollment@Capario.com

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Electronic Remittance Advice (ERA)
Electronic Funds Transfer (EFT)
Enrollment Form

Registration with Office Ally at officeally.com is required to receive an ERA from HSM.

A. CLINIC INFORMATION - ALL FIELDS REQUIRED

Clinic Name: ______________________________

Clinic Tax ID: ______________ Clinic NPI ______________

Office Ally User Name ______________________________

B. CONTACT INFORMATION - ALL FIELDS REQUIRED

Contact Name: ______________________________

Phone: ______________ Fax: ______________

Email: ______________________________

C. PAYMENT METHOD

Paper Check ☐ Electronic Funds Transfer (EFT) ☐
If EFT is selected please complete SECTION D

D. BANK INFORMATION - Required Only if EFT payment method is selected.

Bank Name: ______________________________

Bank Routing Number (9 Digits) ______________

Account Number: ______________________________

Account Type: Savings ☐ Checking ☐

A voided check is required with EFT enrollment. Please fax copy of check with enrollment form.
To be eligible for EFT from HSM your office must be setup for Electronic Remittance Advice.

E. AUTHORIZED SIGNATURE

Signature: ______________________________

Print Name: ______________________________

Title: ______________________________

Date: ______________________________

Please fax completed form to HSM ERA Enrollment at 651-501-9644

This form will certify that Office Ally is authorized to receive the ERA for the clinic tax ID listed.
Contact HSM Provider Services at 800-432-3640 with questions regarding your enrollment.

v12/09