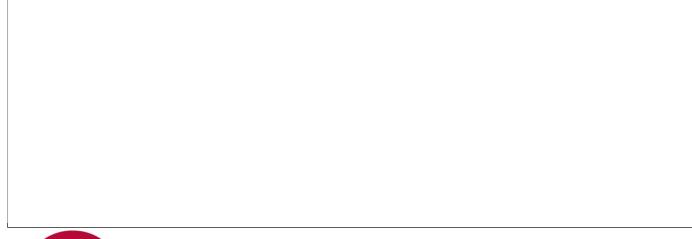


## PAYER ENROLLMENT INSTRUCTIONS FOR

### **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**







#### STEP 3: COMPLETE CAPARIO ENROLLMENT SPREADSHEETS

- Capario Provider Spreadsheet This is completed for each <u>new</u> provider.
   <a href="http://www.capario.com/downloads/xls/provider-bulk-spreadsheet.xlsx">http://www.capario.com/downloads/xls/provider-bulk-spreadsheet.xlsx</a>
- Capario Payer Enrollment Spreadsheet This is completed when requesting enrollment with a payer for providers <u>previously</u> 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: <a href="mailto:provider.enrollment@capario.com">provider.enrollment@capario.com</a>

#### **Questions? Contact us:**

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





# 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	N - 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	l - Required Only if EFT payment method is selected.
	Bank Name:	
	Bank Routing Number	( 9 Digits)
	Account Number:	<u></u>
	Account Type:	Savings Checking
		quired with EFT enrollment. Please fax copy of check with enrollment form. from HSM your office must be setup for Electronic Remittance Advice.
E.	AUTHORIZED SIGNA	TURE
	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.