# The InstaMed Network Electronic Funds Transfer Enrollment Form

**INSTRUCTIONS: Please complete this form to enroll in InstaMed Electronic Funds Transfer, InstaMed HIPAA Transactions, and the PHCS Savility™ Provider Portal. If you have questions about this form, please contact MultiPlan's PHCS Savility Provider Service team at (877) 728-4548.**

**Please return the completed form, along with a voided check to enroll in Electronic Funds Transfer, via fax or mail to:**

**FAX: (877) 755-3392** **MAIL: InstaMed**
**P.O. Box 58790**
**Philadelphia, PA 19102**

## SECTION ONE – GENERAL INFORMATION

### Provider Information (*all information is required unless otherwise noted*)

| | **Administrator Contact Information** |
|---|---|
| **MultiPlan Provider ID** | |
| **Provider Name** | **Name** |
| **Address** | **Phone** |
| **City** **State** **Zip** | **Email** |
| **Billing NPI** | **Fax (optional)** |

**-- PLEASE ATTACH AN UPDATED PROVIDER ROSTER WITH THE ENROLLMENT FORM --**

### Tax IDs

Please provide your billing Tax ID(s) for the above named provider. Tax ID is required for account setup.

**Tax ID**: ________________ **Tax ID**: ________________ **Tax ID**: ______________ **Tax ID**: ________________

## SECTION TWO – HIPAA TRANSACTIONS

**Please select your options to receive Electronic Remittance Advice (*ERA*):**

- ☐ Receive ERA through Provider Portal only
- ☐ Receive ERA via Secure File Transfer Protocol (*SFTP*)
- ☐ Receive ERA through existing Clearinghouse

Clearinghouse Name: __________________________

**Please select your options to submit Claims:**

- ☐ Upload PHCS Savility claims through Provider Portal
- ☐ Submit PHCS Savility claims directly to MultiPlan via InstaMed (*SFTP*)
- ☐ Submit PHCS Savility claims through existing Clearinghouse

*Please use the Payer Identification Number 13306; if your clearinghouse does not offer this Payer Identification Number electronically, please call (877) 728-4548.*

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Healthcare Payments Simplified

PHCS SAVILITY

## SECTION THREE – ELECTRONIC FUNDS TRANSFER

**Please select your options for Electronic Funds Transfer:**

- ☐ Use Electronic Funds Transfer to receive payment for claims (complete form below)
- ☐ Receive paper checks

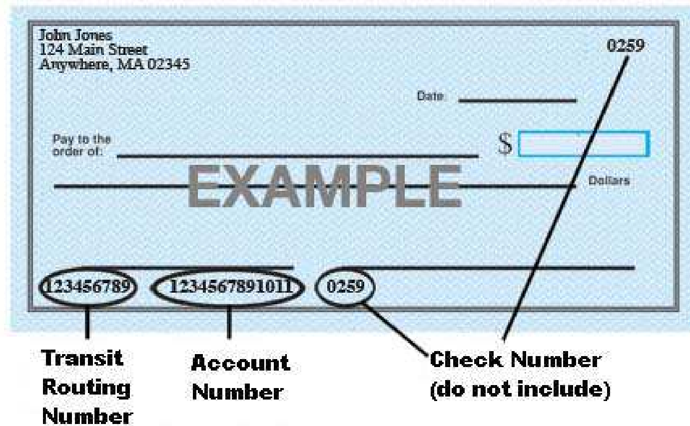
If you choose to use Electronic Funds Transfer, complete the following information and attach a voided check or photocopy of a voided check. One form is required per bank account. You should begin to receive electronic reimbursement on behalf of PHCS Savility payers after July 1, 2009.

### Settlement Information

| | |
|---|---|
| Bank Name | Bank Address |
| Transit Routing Number (TRN) | City State Zip |
| Account Number | Account Type: ☐ Savings ☐ Checking |

**IMPORTANT: Please attach voided check or a photocopy of a voided check:**

<attach voided check here>




### Authorization

The undersigned authorizes InstaMed Communications, LLC D.B.A InstaMed to make electronic debits, payments and adjusting entries to the bank account at the depository financial institution (depository) named above for services performed under the network participation agreement between the organization identified above and InstaMed and its affiliates. Such debits, payments and entries shall be made through the regional automated clearinghouse (ACH) associations, subject to the operating rules of the National Automated Clearinghouse Association. This authorization is to remain in full force and effect until InstaMed has received written notice of its termination, allowing us reasonable opportunity to act on it, but in no event later than thirty (30) days advance notice. Revocation will not apply to transactions initiated before the effective date of such revocation. Although no fees are currently charged for this service, in the event InstaMed elects to impose fees, we will notify you in advance. If you do not terminate this authorization after such notice, you authorize InstaMed to deduct such fees from the transfers of funds owed to you under the network participation agreement to the depository specified above. InstaMed may cease providing any or all of these services upon notice to the Primary Contact named above. The undersigned certifies that the above information is true and accurate in all respects and that the undersigned has the authority to initiate the actions requested herein and will promptly notify InstaMed of any changes to the information on this form in writing. InstaMed reserves the right, in its sole discretion, to provide the information regarding the undersigned provided in this form, and the undersigned hereby consents to the provision of such information by InstaMed, to MultiPlan, Inc. and/or its affiliates, provided that (i) the undersigned has not requested in writing that InstaMed not disclosure such information to MultiPlan, Inc. and/or its affiliates, and (ii) that any such disclosure is otherwise permitted under all applicable legal and regulatory requirements and healthcare and payment industry security standards related to the collection, retention and use of such information.

### Authorized Signature Required

| | |
|---|---|
| Printed Name | Title |
| Signature | Date |

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