Electronic Remittance Advice (ERA) Authorization Agreement

Electronic Remittance Advice (ERA) is an electronic version of an Explanation of Payment (EOP) and is the required method to provide an explanation of claim payments and denials. ERA also avoids the risks associated with mailing and handling paper remittance advices, ensuring ERAs are directly deposited into a specific electronic mailbox.

Provided below are instructions regarding completion of this form. In addition, an Appendix available at the bottom of this form to assist you in correctly completing the form field by field. Please, do NOT mail or fax this page or the Appendix when submitting the ERA Authorization Agreement.

The ERA Authorization Agreement may be used to **newly enroll** a provider in ERA and/or **change existing ERA information**.

To complete ERA Authorization Agreement you will need to know or be able to obtain all or some of the following information:

- National Provider Identifier
- Basic Business Office Data (i.e., address, phone, fax, email address, etc.)
- Specific Office Data (i.e., vendor information, contact information, etc.)
- IRS Tax Identification Data
- Trading Partner Information

If you DO NOT have a Trading Partner ID, you MUST obtain one before completing this ERA Authorization Agreement. To obtain a Trading Partner ID visit the Alabama Medicaid Interactive Portal. At the bottom of the screen, under Documentation, CLICK "Trading Partner ID Request Form". Complete the appropriate sections and submit to the EMC Help Desk. Upon processing of the Trading Partner ID Request Form, a PIN letter will be generated and mailed to you. Once a Trading Partner ID is established, you may continue this ERA Authorization Agreement process and provide the Trading Partner ID in the designated field.

To submit the ERA Authorization Agreement you must:

- Complete all required fields, verifying data is accurate.
- Print the form and obtain the written signature of the person authorized to add or change ERA information for the provider.
- Mail or fax the form, not including this guide page or the appendix, to HPES EMC Help Desk at:

  P.O. Box 244035, Montgomery, AL 36124
  – OR–
  301 Technacenter Drive, Montgomery, AL 36117-6008

  Fax #: 334-215-4272.

If you have concerns/questions regarding the completion of the ERA Authorization Agreement you may contact the EMC Help Desk toll free at 1-800-456-1242.

If you have concerns/questions regarding CAQH Core ACA Phase III Operating Rules, such as reassociation of EFT and ERA or how to resolve of late or missing EFT or ERA, please browse our CAQH Core Operating Rules webpage at: http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.5.2_Phase_III.aspx

Provider Information

Provider Name

Provider Address

Street (NOT a P. O. Box)

(Suite, Room, etc.)

City | **State/Province** | **Zip Code/Postal Code**

Provider Identifiers Information

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

National Provider Identification (NPI)

Other Identifier(s)

Assigning Authority

◯ Medicaid

Trading Partner ID

Provider Contact Information

Provider Contact Name | **Title**

Telephone Number | **Telephone Number Extension**

Email Address | **Fax Number**

Provider Agent Information

Provider Agent Name

Provider Agent Contact Name

Telephone Number | **Email Address**

Electronic Remittance Advice Information

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

National Provider Identifier (NPI)

Method of Retrieval

- ☐ Web Download from Health Plan-Software Vendor
- ☐ Web Download from Health Plan-Clearinghouse
- ☐ Web Download from Health Plan-Direct Access/Download
- ☐ State Agency Main Office Connect Direct
- ☐ State Agency Provider Disbursement from Main Office
- ☐ Other

Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name

Clearinghouse Contact Name

Telephone Number

Email Address

Electronic Remittance Advice Vendor Information

Vendor Name

Vendor Contact Name

Telephone Number

Email Address

Submission Information

Reason for Submission

☐ New Enrollment ☐ Change Enrollment

I (we) request to receive Remittance Advice (RA) information and authorize the information to be deposited in our electronic mailbox. I (we) accept financial responsibility for costs associated with the receipt of Electronic RA information.

I (we) understand that paper-formatted RA information will continue to be sent o my (our) mailing address as maintained at HP until I (we) submit an Electronic RA Certification Request Form.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Authorized Signature

Written Signature of Person Submitting Enrollment

Printed Name of Person Submitting Enrollment

Printed Title of Person Submitting Enrollment

Submission Date

Below is an explanation of the fields on the ERA Authorization Agreement form and the expected entry:

Field	Description
Provider Name	Enter the name of the provider to whom remittance advice applies. This name should be the same as what is shown on the remittance advice and the provider file.
Provider Address	Street, City, State/Province and Zip Code/Postal Code – Enter the full address of the provider for which this ERA Authorization Agreement applies.
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (FEIN)	Enter the Tax ID associated with the provider for which this ERA Authorization Agreement applies.
Provider National Provider Identifier (NPI)	Enter the NPI associated with the provider for which this ERA Authorization Agreement applies.
Other Identifier	Enter the Medicaid ID assigned to the provider for which the ERA Authorization Agreement applies.
Assigning Authority	Click the Assigning Authority of the Other Identifier previously mentioned. The available selection contains the term Medicaid as this is the only Other Identifier allowed.
Trading Partner ID	Enter the Trading Partner ID assigned to the provider for which the ERA application applies.
Provider Contact Name	Enter the name of the person, associated with the provider, who should be contacted with questions regarding this ERA Authorization Agreement.
Title	Enter the title of the Provider Contact previously mentioned.
Telephone Number and Telephone Number Extension	Enter the full phone number as well as a specific phone line extension, if extension is known, for the Provider Contact previously mentioned.
Email Address	Enter the full email address for the Provider Contact previously mentioned.
Fax Number	Enter the full fax number for the Provider Contact previously mentioned.
Provider Agent Name	Enter the name of the Agent who may be working on behalf of the provider such as a Credentialing Agent/Agency.
Provider Agent Contact Name	Enter the name of a contact for the provider's Agent previously mentioned.
Telephone Number	Enter the phone number of the provider's Agent previously mentioned. If an Agent contact is listed this should be the phone number of the Agent contact.
Email Address	Enter the email address of the provider's Agent previously mentioned. If an Agent contact is listed this should be the email address of the agent contact.
Account Number Linkage to Provider Identifier/Provider National Provider Identifier (NPI)	Enter the NPI of the provider for which the ERA application applies.
Method of Retrieval	Select the method by which the ERA will be retrieved.

Field	Description
Email Address	Enter the email address of the provider's Agent previously mentioned. If an Agent contact is listed this should be the email address of the agent contact.
Account Number Linkage to Provider Identifier/Provider National Provider Identifier (NPI)	Enter the NPI of the provider for which the ERA application applies.
Method of Retrieval	Select the method by which the ERA will be retrieved.
Clearinghouse Name	Enter the name of the Clearinghouse who may be working on behalf of the provider.
Clearinghouse Contact Name	Enter the name of a contact for the Clearinghouse previously mentioned.
Telephone Number	Enter the phone number of the Clearinghouse previously mentioned. If a Clearinghouse contact is listed this should be the phone number of the Clearinghouse contact.
Email Address	Enter the email address of the Clearinghouse previously mentioned. If a Clearinghouse contact is listed this should be the email address of the Clearinghouse contact.
Vendor Name	Enter the name of the Vendor who may be working on behalf of the provider.
Vendor Contact Name	Enter the name of a contact for the Vendor previously mentioned.
Telephone Number	Enter the phone number of the Vendor previously mentioned. If a Vendor contact is listed this should be the phone number of the Vendor contact.
Email Address	Enter the email address of the Vendor previously mentioned. If a Vendor contact is listed this should be the email address of the Vendor contact.
Reason for Submission	Select a reason for which you are submitting the application.
Written Signature of Person Submitting the Enrollment	Upon printing the form, the authorized person MUST also sign this line.
Printed Name of Person Submitting Enrollment	Enter the name of the authorized person completing the form.
Printed Title of Person Submitting Enrollment	Enter the title of the authorized person completing the form.
Submission Date	Enter the date, in MM/DD/CCYY format, on which the form is being submitted.