Blue Cross Blue Shield of Western New York

Attention Providers:

Blue Cross Blue Shield of Western New York sends an ERA for every claim submitted to EDS. In order to ensure the correct delivery for your ERAs, please complete the Electronic Remittance Advice (ERA) Authorization Form.

Payer:	Blue Cross Blue Shield of Western New York
Payer ID:	00801 CBNYW 89070
For Enrollment Questions:	Contact the EDS Enrollment Department at (800) 482-3518 or Enrollment@edsedi.com
Enrollment Application:	**Electronic Remittance Advice (ERA) Authorization Agreement**
Email or Fax Application to:	EDI@Echohealthinc.com Fax (440) 835-5656 Mail to: Echo Health Inc,810 Sharon Drive,Westlake, OH 44145
Approval Process and Timeframes:	Blue Cross Blue Shield of Western New York automatically sends an ERA for every claim submitted through EDS. ERAs will be automatically to the EDS Portal upon receipt.

ECHO® Payments Simplified

Standard Form

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

INSTRUCTIONS

- This is a fillable form. Type your information into the form on your screen, or print the form and fill in the information.
- Complete all sections that apply to your enrollment choice *(EFT & ERA, EFT, or ERA)*. **Note**: Information in yellow text boxes is ***required*** for **all enrollment types**. In addition, information in blue text boxes is ***required*** for **EFT**, information in red text boxes is ***required*** for **ERA**.
- Enrollments are handled at the TAX ID level. All NPIs associated with the specified TIN will be automatically enrolled.
- If your TAX ID would like to receive payments via more than one bank account, please contact EDI@EchoHealthinc.com.
- Be sure to sign the form. Fax, postal mail or email the completed form (secure email is recommended if you choose this method) to ECHO Health, Inc. Information on how to send to ECHO is listed at the end of this form.
- For information about the status of your enrollment, or for any other questions, please contact ECHO at 440.835.3511 or EDI@EchoHealthinc.com.

EFT & ERA **EFT Only** **ERA Only**

Payer / Insurance Company Name: _____

(Please specify only one Payer per form)

For security purposes, please supply an ECHO Draft Number and matching Draft Amount to validate against your Tax ID. The Draft Number will be a 9-digit payment number beginning with a 1, 2 or a 9. **NOTE:** For **ERA only**, Draft Number and Draft Amount are **not required**.

ECHO Draft Number _____ **ECHO Draft Amount $** _____

EFT/ERA DEG 1 – Provider Information

Provider Name: _____

(Complete legal name of institution, corporate entity, practice or individual provider)

DBA: _____

Street: _____

(The number and street name where a person or organization can be found)

City: _____ **State/ Province:** _____ **ZIP Code/Postal Code:** _____

(City associated with provider address field)

(ISO-3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.)

(System of postal-zone codes [zip stands for "zone improvement plan"] introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.)

EFT/ERA DEG 2 – Provider Identifiers Information

Provider Identifiers

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

(A Federal Tax Identification Number, also known as an Employer Identification Number [EIN], is used to identify a business entity)

If Provider has an NPI (National Provider Identifier) number, please enter it: _____

(Required when Provider has been enumerated with an "NPI")

NPI is A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

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EFT/ERA DEG 3 – Provider Contact Information

Provider Contact Name: [redacted]
(Name of contact in provider office for handling EFT issues)

Provider Contact, Title *(optional):* [redacted]

Telephone Number: [redacted] **Telephone Extension** *(optional):* [redacted]
(Associated with contact person)

E-mail Address: [redacted]
(An electronic mail address at which the health plan might contact the provider)

EFT/ERA DEG 4 – Provider Agent Information

Provider Agent Name: [redacted]
(Name of provider's authorized agent)

Provider Agent Contact Name: [redacted]
(Name of contact in agent office for handling EFT issues)

Provider Agent Contact, Title *(optional):* [redacted]

Telephone Number: [redacted] **Telephone Extension** *(optional):* [redacted]
(Associated with Provider Agent contact person)

E-mail Address: [redacted]
(An electronic mail address at which the health plan might contact the provider)

EFT DEG 7 – Financial Institution Information

Financial Institution Name: [redacted]
(Official name of the Provider's financial institution)

Telephone Number: [redacted] **Telephone Extension (optional):** [redacted]
(A contact phone number at the Provider's bank)

Financial Institution Routing Number: [redacted]
(A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited)

Type of Account at Financial Institution: [redacted]
(The type of account the provider will use to receive EFT payment, e.g., Checking, Saving)

Provider's Account Number with Financial Institution: [redacted]
(Provider's account number at the financial institution to which EFT payments are to be deposited)

Account Number Linkage to Provider Identifier. Select one option below.
(Provider preference for grouping [bulking] claim payments – must match preference for v5010 X12 835 advice)

○ **Provider Tax Identification Number (TIN)** ○ **National Provider Identifier (NPI)**

ERA DEG 7 – Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)
(Provider preference for grouping [bulking] claim payment remittance advice – must match preference for EFT payment)

Provider Tax Identification Number (TIN): [redacted]
(Required if NPI is not applicable)

National Provider Identifier (NPI): [redacted]
(Required if TIN is not applicable)

Method of Retrieval: [redacted]
(The method in which the provider will receive the ERA from the health plan [e.g., download from health plan website, clearinghouse, etc.])

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ERA DEG 8 – Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name: [redacted]
(Official name of provider's clearinghouse)

Clearinghouse Contact Name: [redacted]
(Name of a contact in the clearinghouse office for handling ERA issues)

Clearinghouse Telephone Number: [redacted]
(Telephone number of contact)

Clearinghouse E-mail Address: [redacted]
(An electronic mail address at which the health plan might contact the provider's clearinghouse)

ERA DEG 9 – Electronic Remittance Advice Vendor Information

Vendor Name: [redacted]
(Official name of provider's vendor)

Vendor Contact Name: [redacted]
(Name of a contact in vendor office for handing ERA issues)

Vendor Telephone Number: [redacted]
(Telephone number of contact)

Vendor Email Address: [redacted]
(An electronic mail address at which the health plan might contact the provider's vendor)

EFT DEG 8/ERA DEG 10

Reason for Submission: ○ **New Enrollment** ○ **Change Enrollment** ○ **Cancel Enrollment**

Authorized Signature *(The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment).*

☐ By signing below, provider acknowledges that the provider has read, agrees that it is subject to and agrees to comply with all terms and conditions for Quick Post Advisor enrollment, including those relating to the delivery of the services, which can be found at: https://enrollments.echohealthinc.com/TermAndCondition.aspx

Written Signature of Person Submitting Enrollment: _____
(A [usually cursive] rendering of a name unique to a particular person used as confirmation of authorization and identity)

Printed Name of Person Submitting Enrollment: [redacted]
(The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment)

Submission Date ***(CCYYMMDD):*** [redacted]
(The date on which the enrollment is submitted)

Mail, fax or e-mail completed form (secure e-mail is recommended) to ECHO Health, Inc.

Mail to: **ECHO Health, Inc.**
810 Sharon Drive
Westlake, OH 44145

Fax: 440.835.5656

email: EDI@Echohealthinc.com

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