APIPA (UnitedHealthCare)

Attention Providers:

In order to start receiving your ERAs for APIPA (UnitedHealthCare) through EDS, you will need to print and review the enrollment form. Please sign the form and submit to EDS with required documentation noted below.

Payer:	APIPA (UnitedHealthCare)
Payer ID:	GP133
For Enrollment Questions:	Contact the EDS Enrollment Department at (800) 482-3518 or Enrollment@edsedi.com
Enrollment Application:	**Electronic Remittance Advice (ERA/835) Request Form and EFT Authorization Agreement**
Email or Fax Application to:	Enrollment@edsedi.com Fax (800) 482-3518
Approval Process and Timeframes:	Payer estimates 2-3 business days for processing.

Special Instructions: **Registration for APIPA (UnitedHealthCare) ERAs also registers you for the following Payers .**

Amerigroup of Florida EVERCARE of New Mexico / UnitedHealthcare Healthy Michigan Dental (UHC) Medicaid of Mississippi (UHC Community Plan) Medicaid of New Jersey (UHC Community Plan - NJ) Medicaid of New York (UHC Community Plan) Medicaid of Tennessee (UHC Community Plan) Medicaid of Texas (UHC Community Plan) United HealthCare Community Plan United Healthcare Community Plan (AHCCCS) United Healthcare Community Plan AZ-Evercare United Healthcare Community Plan (AZ Healthnet) United Healthcare Community Plan (FL) United Healthcare Community Plan (GA Medicare) United Healthcare Community Plan (HI Medicare) United Healthcare Community Plan (KS) United Healthcare Community Plan (MA) United Healthcare Community Plan (MI Medicare)	United HealthCare Community Plan - MS United HealthCare Community Plan - New Mexico EverCare United HealthCare Community Plan - NJ (Formerly Known as Americhoice) United HealthCare Community Plan - NY (Formerly Known as Americhoice) United Healthcare Community Plan (Oxford) United HealthCare Community Plan - PA (Formerly Known as Americhoice) United HealthCare Community Plan - RI (Formerly known as Americhoice) United HealthCare Community Plan - TN (Formerly Known as Americhoice) United Healthcare Community Plan (WA Medicare) United healthcare Community Plan (WI) United Healthcare MI Dental United HealthCare of the Midwest

ERA/835 Request form

Requestor Name _____

Business Name as Listed on your Taxes _____

Tax ID Number _____

Payee ID NPI

Where would you like your remits posted?

_____ Scion Provider Web Portal

_____ Scion SFTP (Secure site)

- We will send you the credentials to access

__X__ Office SFTP (Secure Site)

Please include log on credentials Send to DentalXChange

_____

Office Contact info for additional questions or information:

Name_____

Phone Number_____

E-Mail_____

_____ _____

Signature of Office Representative Date

Please email completed form to providerservices@sciondental.com or fax it to 262-721-0722

Instructions for the

Electronic Funds Transfer (EFT) Authorization Agreement

RECEIVE ELECTRONIC CLAIMS PAYMENTS FASTER THAN MAILING PAPER CHECKS—FOR FREE!

Three Easy Steps for EFT Enrollment

1. Fill in the attached **EFT Authorization Agreement** form.
2. Return the completed form with a scanned or faxed copy of a *voided check* from your financial institution.
3. Send the form and *voided check* to Provider Services via email or fax. (Please see the form for the email address and fax number.)

Why enroll in EFT?

Direct Checking and Savings Account Payments

Prompt payments for services rendered is always a concern. Electronic Funds Transfer (EFT)—a secure and free online procedure—replaces paper checks for services rendered. This access enables you to:

- Receive claims payments in established bank accounts up to a week faster than paper checks.
- Decrease incoming mail, eliminating delays or mistakes due to hardcopy procedures.
- Lower administrative costs, save paper, and take advantage of a convenient audit trail.
- Review and verify remittances easily and conveniently on the Provider Web Portal—at no charge to your office.

Why use the web portal?

Online Resources for Enrolled Providers

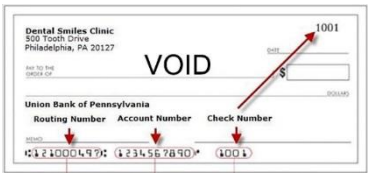
Secure login access to the system—from anywhere at any time—allows you and your authorized office staff to handle a variety of routine tasks, such as the following.

- Verify member eligibility.
- Set up office appointment schedules, which automatically verify eligibility and fill in claim forms for online submission.
- Submit claims and verify claims status for services rendered.
- Submit authorization requests and send digital attachments, such as Explanation of Benefits (EOBs) and treatment plans.
- Check patient treatment history for specific services.

SCION DENTAL, INC
A SKYGEN USA COMPANY

Electronic Funds Transfer (EFT) Authorization Agreement

Get your reimbursement faster and easier with EFT! To receive your payments by EFT, please complete this form and return it with a scanned or faxed copy of a voided check. *(This Authorization Agreement will not be valid without a* voided check.*)*

Submission Options			
Send this completed form and voided check to Scion Dental via:	**Fax:** 800-866-0006	**Email:** enrollment@dentalxchange.com	
Submission Reason			
Select one checkbox.	❑ New EFT Authorization | ❑ Account or bank change to existing EFT Authorization		
Provider Information			
Provider Name *(Include d/b/a, if any.)*	Taxpayer Identification Number	*Select one checkbox.* ❑ SSN | ☒ EIN	
Street Address			
City	State	Zip Code	
Phone Number	Email Address		
Financial Institution Information			
Financial Institution Name	Financial Institution Routing Number *(Include 9 digits with any leading zeros.)*		
Account Number *(Include up to 10 digits with any leading zeros.)*	*To indicate account type, select one checkbox.* ❑ Checking Account | ❑ Savings Account		
Note: Please return this form with a *voided check* or the Authorization Agreement will not be valid.			

Authorization

I hereby authorize Scion Dental, on behalf of itself and its affiliates, (hereinafter "Company") to initiate credit entries to the account at the financial institution listed above for all payments. I authorize and request the financial institution to accept credit entries by Company to such account and to credit the same to such account. If Company credits more money than the correct payment amount due to duplicate electronic funds transfers (where "duplicate" is defined as multiple electronic funds transfers received for the same services rendered, the same membership, and the same dates of service) or erroneous electronic funds transfers (where "erroneous" is defined as complete electronic funds transfers received in error) I authorize Company to withdraw the overpayment electronically. I accept responsibility for any resulting loss of payment and release Company from any liability for or arising from my failure to submit accurate or updated information to Company. I understand that I must communicate any changes in my information to Company. This authorization is effective as of the signature date below and is to remain in full force and effect until Company has received written notification from me of its termination or Company notifies me that this service has been terminated. I agree to provide notification of change/termination 30 days in advance. By signing this authorization, I acknowledge that I have read and agree to the conditions set forth herein. Furthermore, I certify that the information provided is true and accurate in all respects and that I have been duly authorized to enter into this agreement.

Printed Name	Title
Authorized Signature	Date