CarePlus HEALTH PLANS

EFT and ERA enrollment form instructions

You must complete this form to initiate electronic funds transfer (EFT) and electronic remittance advice (ERA).

Type your responses into the electronic version of the form and save them before printing. If you choose to print a blank form and complete it, please print legibly using only black or blue ink.

The following instructions will guide you through completion of the form. If you need additional assistance, call CarePlus Provider Operations at 1-866-220-5448; choose Option 1 and then Option 4. Assistance is available Monday through Friday, 8 a.m. to 5 p.m., Eastern time.

Provider information – Please fill out completely.

- Provider name – Complete legal name of the institution, corporate entity, practice or individual provider
- Provider address – The address of the person or organization listed under "Provider name." For the state name, please use the two-letter postal service state abbreviation.

Provider identifiers

- Federal Tax Identification Number (TIN) or employer identification number (EIN) – The TIN is a nine-digit identification number used for tax purposes in the United States.
- National Provider Identifier (NPI) – The NPI is a unique 10-digit number for covered healthcare providers.
- Assigning authority (ERA) (optional entry) – The organization that issues and assigns the additional identifier requested on the form (e.g., Medicare)
- Trading partner ID (ERA) (optional entry) – The provider's submitter ID, assigned by the health plan, the provider's clearinghouse or a vendor

Provider contact information – Information for this section should be for the office person who handles EFT/ERA issues.

Financial institution information for EFT

- Financial institution name – Official name of the provider's financial institution
- Financial institution routing number – The nine-digit identifier of the financial institution where the provider maintains the account in which payments are to be deposited
- Type of account – Type of account in which EFT payments are to be deposited
- Account number – Account in which EFT payments are to be deposited

ERA enrollment additional information

- Clearinghouse name – Official name of the provider's clearinghouse
- Telephone number – Corporate phone number of the provider's clearinghouse
- Email address – Registration or support email for provider's clearinghouse
- Method of retrieval – Clearinghouse

Please note: To complete the ERA enrollment process, you must sign up with Change Healthcare.

- Go to **https://www.changehealthcare.com/support/customer-resources/enrollment-services/**.

- Under the Medical and Hospital section, click on “ERA Enrollment Forms” and select "ERA Merge Group Provider Setup Form."
- Complete and submit the form to Change Healthcare via the fax number or email address listed on the form.

Submission information

Reason for Submission – *check appropriate box*:

- New enrollment – For first time registration.
- Change enrollment – For registered users with changes to their registration or bank account info
- Cancel enrollment – For registered users who would like to cancel their registration

Indicate which of the following you will include with your submission – one is required):

- Voided check – Attach a voided check to the form to confirm routing and account number. Voided check must be provided if a checking account will be used.
- Bank letter – Attach a letter, with the bank’s letterhead, that formally certifies the account owner’s routing and account number.

Authorized signature

- Written signature – The signature of an individual authorized by the healthcare provider or provider’s agent to initiate, modify or terminate an enrollment
- Printed name – The printed signature of the individual authorized by the provider or provider’s agent to initiate, modify or terminate an enrollment
- Printed title of person submitting enrollment – The title of the authorized representative
- Submission date – The date on which the enrollment is submitted
- Request start/change/cancel date – The effective date the provider would like to start new enrollment, change enrollment or cancel enrollment

Please fax the completed form to **1-855-659-7966** or mail it to this address:

CarePlus Health Plans
ATTN: Provider Operations
11430 NW 20th St., Suite 300
Miami, FL 33172

If you have questions about this form, please call CarePlus Provider Operations at 1-866-220-5448; choose Option 1 and then Option 4. Assistance is available Monday through Friday from 8 a.m. to 5 p.m., Eastern time.

Please note: You must contact your financial institution to arrange for delivery of the CORE-required minimum CCD+ data elements needed for reassociation of the payment and the ERA. See the Phase III CORE EFT and ERA Reassociation (CCD+/835) rule, version 3.0.0. at www.caqh.org/Host/CORE/ EFT-ERA/ EFTERA_Reassociation_Rule.pdf.

CarePlus HEALTH PLANS

CarePlus Health Plans Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Authorization Agreement

Provider information

Provider name _____

Provider address

Street _____

City _____ State _____ ZIP Code _____

Provider identifiers

Federal Tax Identification Number or employer identification number (EIN) _____

National Provider Identifier (NPI) _____

Assigning authority (optional) _____

Trading partner ID (optional) _____

Provider contact information

Provider contact name _____

Telephone number _____

Email address _____

Fax number _____

Financial institution information for EFT

Financial institution name _____

Financial institution routing number _____

Type of account ☐ Checking ☐ Savings

Account number _____

ERA clearinghouse information*

Clearinghouse name _____

Telephone number _____

Email address _____

Method of retrieval _____

Submission information

Reason for submission ☐ New enrollment ☐ Change enrollment ☐ Cancel enrollment

Indicate which of the following you will include with your submission (one is required):

☐ Voided check ☐ Bank letter

Authorized signature

Written signature _____ Printed name _____

Printed title of person submitting enrollment _____

Submission date _____ Requested start/change/cancel date _____

* To complete the ERA enrollment process, you must sign up with Change Healthcare.