Electronic Remittance Advice (835) and EFT Authorization Agreement

Please complete all applicable sections. Upload this form and a copy of a voided check to PacificSource through our secure website, InTouch. (Login at **PacificSource.com/providers**.) You are also welcome to fax or use secure email to send the form and voided check to us.

Please type or print legibly in black or blue ink. Complete all applicable sections.

Provider Information

I wish to enroll in (choose one) EFT and 835/ERA EFT only/EOP available through InTouch

Provider Name (as it appears on bank account) ______________________________

Street ______________ City ______________ State ______ ZIP ______________

Provider Federal Tax Identification Number (TIN) ______________ National Provider Identifier (NPI) ______________

Provider Contact Name ______________________ Phone (________)______________

Email Address ____

Bank Information

Financial Institution Name ____

Street ______________ City ______________ State ______ ZIP ______________

Financial Institution Routing Number ______________ Type of Account at Financial Institution Checking Savings

Provider's Account Number with Financial Institution ______________________________

Account Number Linkage to Provider Identifier (choose one)

- Provider Tax ID (TIN)
- National Provider Identifier (NPI)

Reason for Submission (choose one)

- New Enrollment
- Change Enrollment
- Cancel Enrollment

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

- Provider Tax ID (TIN)
- National Provider Identifier (NPI)

Include with Enrollment Submission Voided Check Bank Letter

Clearinghouse Name ______________________ Clearinghouse Contact Name ______________________

Disclosure

By submitting this form, I authorize the above named contact person to execute, implement, and perform all functions necessary for my facility to receive electronic funds transfer (EFT) payments, and (if requested) electronic remittance advice, from PacificSource.

Printed Name of Person Submitting Enrollment ______________________________

Signature of Person Submitting Enrollment ______________________________

Printed Title of Person Submitting Enrollment ______________________________

Submission Date ______________________ Requested EFT/ERA Effective Date ______________

Please return completed form by mail or fax to the address in the upper right corner. Or upload this form and a copy of a voided check to PacificSource through our secure website, InTouch. (Login at **PacificSource.com/providers**.)

See page two for terminology.

EFT/ERA Enrollment Glossary of Terms

Provider Information

- **Provider Name –** Complete legal name of institution, corporate entity, practice or individual provider.
- **Street –** The number and street name where a person or organization can be found.
- **City –** City associated with provider address field.
- **State/Province –** ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.
- **ZIP –** 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.
- **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.
- **National Provider Identifier –** 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 the 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.
- **Provider Contact Name –** Name of a contact in provider office for handling EFT/ERA issues.
- **Phone –** Number associated with contact person.
- **Email Address –** An electronic mail address at which the health plan might contact the provider.

Bank Information

- **Financial Institution Name –** Official name of the provider's financial institution.
- **Street –** Street address associated with receiving depository financial institution name field.
- **City –** City associated with receiving depository financial institution address field.
- **Financial Institution Routing Number –** A nine-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 –** The type of account the provider will use to receive EFT payments, e.g., Checking, Saving.
- **Provider's Account Number with Financial Institution –** Provider's account number at the financial institution to which EFT payments are to be deposited.
- **Account Number Linkage to Provider Identifier –** Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice.
- **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 of EFT payment.
- **Voided Check –** A voided check is attached to provide confirmation of Identification/Account Numbers.
- **Bank Letter –** A letter on bank letterhead that formally certifies the account owners routing and account numbers.
- **Clearinghouse Name –** Official name of the provider's clearinghouse.
- **Clearinghouse Contact Name –** Name of a contact in clearinghouse office for handling ERA issues.

Disclosure

- **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.
- **Printed Name of Person Submitting Enrollment –** The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment.
- **Printed Title of Person Submitting Enrollment –** The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment.
- **Submission Date –** The date on which the enrollment is submitted.
- **Requested ERA Effective Date –** Date the provider wishes to begin ERA; per Phase III CORE Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0: there may be a dual delivery period depending on whether the entity has such an agreement with its trading partner.

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