Optima Health ERA Enrollment

Submit the completed Payer Request Form to:
Inovalon Enrollment
enrollmentsupport@inovalon.com

INSTRUCTIONS

- Complete all sections of the **Payer Request Form**
- Complete this form using group or individual provider information as listed on file with the payer you wish to set up

Note: Some payers require additional documentation to be completed and signed by the provider in order to complete enrollment. If additional forms are required, the required forms will be sent to you for completion.

IMPORTANT: You must specify the payer(s) with which you wish to enroll. If no payers are specified, enrollment forms WILL BE RETURNED.

If you have more than ten payers to enroll, please make additional copies of this form.

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INSTRUCTIONS

Complete one form per TAX ID.

PROVIDER BILLING INFORMATION

Please type your responses directly into the form.

Please check: ☐ New Request ☐ Change Request

Billing Service Name (if applicable)

TIN or INOVALON ID:

Contact Name:

Phone: ( ) Fax: ( ) Email:

Group/Provider Name:

Please check for designation: ☐ Professional ☐ Institutional

Billing Tax ID: Indicate ☐ TIN/EIN ☐ SSN Billing NPI:

Street Address:

City: State: Zip:

Name of Authorized Signee:

Title of Authorized Signee:

PAYER INFORMATION

List payers with which you wish to enroll below. Please refer to the Inovalon Payer List for enrollment requirements. Check the transaction(s) you want to enroll for each payer.

Payer ID	Payer Name	PTAN, Medicaid ID or Provider ID	Claims	ERA

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INSTRUCTIONS

- Please carefully read all instructions before beginning.
- Print these instructions. Refer to them as you complete the registration process.
- Please type provider information on the setup form for ease of processing at Inovalon.
- Due to heightened HIPAA regulations and EFT setup requirements, Inovalon is unable to complete the enrollment process on your behalf. Please contact the payer if you require assistance with the setup process.
- Providers are required to complete online ERA/EFT enrollment on the Optima Health Plan Web site at: **https://www.optimahealth.com/providers/billing-and-claims/eft-era-authorization-agreement-instructions**
- Instructions for changing your receiver to Inovalon can be found here: **https://www.optimahealth.com/providers/billing-and-claims/eft-era-authorization-agreement-instructions**
- Please do not alter any prefilled fields on the Electronic Payment/Remittance Authorization Agreement.
- This payer requires EFT setup.
- Please contact the payer if you require assistance with the setup process; Inovalon is not permitted to complete this process on your behalf.

OptimaHealth

Print Form Save Form

Reset/Clear Form

Electronic Payment/Remittance Authorization Agreement

Detailed instructions on how to complete this form can be found at http://providers.optimahealth.com/billing/Pages/eftera-authorizationagreement.aspx. If you have any questions, please contact Optima Finance at EFT_ERA_INQUIRY@SENTARA.COM.

* *An asterisk denotes required information*

PROVIDER INFORMATION

* Provider Name

PROVIDER IDENTIFIERS INFORMATION

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

Please include TIN numbers for all practice locations EFT applies to

* National Provider Number (NPI)

PROVIDER CONTACT INFORMATION

* Provider Contact Name

* Telephone Number

* Email Address

Provider Numbers

FINANCIAL INSTITUTION INFORMATION

* Financial Institution Name

* 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
(e.g., Preference for Aggregation of Remittance Data)
* Provider Tax Identification Number (TIN)

ELECTRONIC REMITTANCE ADVICE INFORMATION

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

PLEASE NOTE THAT BY CHOOSING TO RECEIVE YOUR PAYMENTS ELECTRONICALLY, REMITS WILL ALSO BE DELIVERED ELECTRONICALLY AND YOU MUST SELECT ONE OF THE OPTIONS BELOW. PAPER REMITS WILL CEASE.

* Method of Retrieval

◯ Print from OptimaHealth.com

YOU MUST HAVE AN OPTIMAHEALTH.COM USERNAME AND PASSWORD

Optimahealth.com Login ID:

Optimabehavioralhealth.com Login ID:

If you do not have an Optimahealth.com username and password, Providers may submit a Provider Connection Enrollment Form which can be found at Optimahealth.com. (https://www.formrouter.net/forms09@SNTRA/OptimaEnrollment.html)

◉ Clearinghouse

◯ Access directly from the Optima secure FTP Site

An Optima Health Finance representative will contact you to discuss specific requirements.

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

* Clearinghouse Name: Medical Claim Corp

Your clearinghouse must have a relationship with the Optima Health clearinghouse of choice: Misys-Payerpath.

SUBMISSION INFORMATION

Please attach a letter on bank letterhead. The letter must be dated within the last 90 days and should include the physical bank address, routing and account number, a bank employee's name, title, email, and phone number.

* Reason for Submission ◯ New Enrollment ◯ Change Enrollment ◯ Cancel Enrollment

Request Type ◯ Optima Health Plan ◯ Optima Behavioral

With your Signature and Printed Name, you are certifying that the account is drawn in the name of the physician or individual Practitioner or the Legal Business name of the Provider or Agent. The Provider or Agent has sole control of the account to which EFT deposits are made in accordance with all applicable Federal regulations and instructions. All arrangements between the Financial Intuition and the said Provider or Supplier are in accordance with all applicable Federal regulations and instructions with the effective date of the EFT authorization. You must notify Optima Health in writing in regards to any changes in the account in sufficient time to allow the contractor and the Financial Institution to act on the change.

The EFT Authorization must be signed by an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment.

* Written Signature of Person Submitting Enrollment

* Printed Name of Person Submitting Enrollment

* Submission Date

* Requested EFT Start/ Change/Cancel Date

* Requested ERA Effective Date

Print Form | Save Form

Reset/Clear Form