# ERA ENROLLMENT INSTRUCTIONS

**HOW DO I ENROLL?**
To enroll and sign up for electronic remit advice (ERA) from iCircle, you must complete the attached forms so that the necessary updates can be made. There are easy to follow instructions in the packet, and our Provider Service and Relations team are standing by anxiously to assist.

**BENEFITS OF ERA:**
Using electronic remit advice (ERA) will allow your practice to receive your information faster and more accurate than standard remit advice (SRA). Additionally, posting your payments will be quicker, more accurate and easier as you will now be able to auto-post the payments.

**Information for Clearinghouse:**

| | |
|---|---|
| Clearinghouse: | Change Healthcare |
| Payer Name: | iCircle |
| Payer ID: | 33884 |

Once the form is completed, you have a few options to return the form to us:

- FAX:
  - 888-519-2816
- MAIL:
  - iCircle Care
  - Attention: ERA Set Up Team
  - 860 Hard Road
  - Webster NY 14580
- Email:
  - ERAsetup@iCircleCNY.org

**YOU MUST BE ENROLLED WITH CHANGE HEALTHCARE OR YOU WILL NEED A CLEARING HOUSE WHICH IS COMPATIBLE WITH CHANGE HEALTHCARE PRIOR TO SET UP. FOR ADDITIONAL INFORMATION ABOUT CHANGE HEALTHCARE, PLEASE VISIT THEIR SITE AT: WWW.CHANGEHEALTHCARE.COM**

icircle

# ELECTRONIC REMITTANCE ADVISE REQUEST FORM

Pre-Requirements: Please read carefully prior to submitting this form:

- Enrolled in the Medicaid/MLTC program
- Have an active certification on file for your Tax ID
- Have a valid and active account with either Change Healthcare or a clearing house which is compatible with Change Healthcare
- To enroll with Change Healthcare, please visit www.changehealthcare.com or call them at 866-371-9066

THIS FORM WILL BE REJECTED IF IT IS ILLEGIBLE OR IF THERE ARE MISSING SEGMENTS. PLEASE ALLOW FOR 7-10 BUSINESS DAYS FOR PROCESSING

| PROVIDER INFORMATION |
|---|
| *Provider Name: |
| *Provider Address: |
| ➢ Street: |
| ➢ City: |
| ➢ State: |
| ➢ Zip Code: |
| **PROVIDER IDENTIFIERS INFORMATION** |
| *Provider Identifiers: |
| *Provider Tax ID (TIN) or Employer Identification Number (EIN): |
| National Provider Identification Number (if applicable): |
| **PROVIDER REMITTANCE ADVICE CLEARING HOUSE INFORMATION** |
| *Clearing House Name:<br>➢ Name of Clearing House |
| **SUBMISSION INFORMATION** |
| *Reason for submission (select one) |
| □ New Enrollment |
| □ Change Enrollment |
| □ Cancel Enrollment |
| ***Authorized Signature:** |
| Printed Name of Person Submitting Enrollment: |
| Printed Title of Person Submitting Enrollment: |
| Date: |
| **WHO WILL RECEIVE THE ERA** |
| *Receiver Name: |
| **ADDITIONAL INFORMATION** |
| □ I would like to sign up for the provider newsletter |
| □ I would like to sign up for the Electronic Funds Transfer (info will be sent to you) |
| Please print your email address: |



The (*) indicates a required field