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 and our Provider Service and Relations team are standing by 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:	VisibilEDI
Payer Name:	iCircle
Payer ID:	ICRCL

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 VisibilEDI OR YOU WILL NEED A CLEARING HOUSE WHICH IS COMPATIBLE WITH VisibilEDI PRIOR TO SET UP. FOR ADDITIONAL INFORMATION ABOUT VisibilEDI, PLEASE VISIT THEIR SITE AT: https://info.visibiledi.com/

For Additional Information pertaining to iCircle Providers, please visit our Provider Page of our website at https://www.icirclecny.org/ or call our dedicated Provider Service Line at (844) 283-2884.

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 an active account with either VisibilEDI or a compatible clearing house which is
- ¬ To enroll with VisibilEDI, please visit https://info.visibiledi.com/

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
[redacted]
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 Electronic Funds Transfer (info will be sent to you)
Please print your email address: