PROVIDER EFT/ERA ENROLLMENT FORM

Manual Enrollment Form

The Provider EFT/ERA service makes it easier for Providers to receive payments and remittance from Payers by eliminating paper checks and EOB's, and depositing funds into your financial institution account via ACH transactions. To get started, just fill out the following Enrollment Form, attach a voided check, and return via fax or mail. Do not email your enrollment form. If you have questions about EFT/ERA enrollment, please call (844) 292-4066.

Be sure you have the following information available when enrolling:

- Provider name, address, and contact information
- Tax ID Number (TIN) and National Provider ID (NPI)
- Banking information for your Financial Institution, including address
- Voided check or bank letter indicating the account to receive EFT/ACH deposits

Want to Enroll By Fax?

You can fill out the Enrollment Form by hand and fax it to us at (314) 567-4503. **To avoid delays in processing, please be sure to use blue or black ink and fill out each field legibly**.

Don't waste paper! Please only fill out and return pages 1 through 5; pages 6 through 10 are for your records only.

Want to Enroll By Mail?

You can also print a hard copy of your completed Enrollment Form and mail it to us. **To avoid delays in processing, please be sure to use blue or black ink and fill out each field legibly**.

Don't waste paper! Please only fill out and return pages 1 through 5; pages 6 through 10 are for your records only.

Mail the completed Enrollment Form and copy of a voided check or bank letter to: **RedCard Systems, Attn: EFT/ERA Enrollment, 744 Office Pkwy, Creve Coeur, MO, 63141.**

After your information is verified, you may receive a call or email (at the contact number or email address indicated in the "Provider Contact Information" section) regarding your enrollment.

NOTE: Providers submitting this enrollment form agree to receive payments from all Payers managed by Red-Card Systems, LLC, unless otherwise specified on page 2.

Reason for Submission (check one): ☐ **New Enrollment** ☐ **Change Enrollment** ☐ **Cancel Enrollment**

NOTE: Fields entered below should be in conformance with CORE Operating Rule 380. Detailed descriptions of these fields can be found starting on page 5.

**= required field*

Provider Information

Provider Name *	
Doing Business As (DBA) Name	
Provider Address Line 1 *	
Provider Address Line 2	
City *	
State/Province *	
Zip Code *	

Provider Identifiers Information:

Provider Federal Tax ID (TIN) or Employer Identification Number (EIN) * – *must be nine numeric digits*	
National Provider Identifier (NPI) * – *must be ten numeric digits*	
Trading Partner ID	

Provider Contact Information:

Provider Contact Name *	
Telephone Number *	
Telephone Number Ext	
Email Address *	
Fax Number *	

Payer Information: Choose which payer(s) and service(s) you are enrolling for.

Enrolling for (*check one per payer*)	**Payer ID**	**Payer Name**	**Method of ERA Retrieval *(check one if enrolling for ERA)***	**Clearinghouse to Receive ERA *(list of available clearinghouses is below this table)***
☐ EFT only ☐ EFT and ERA	13193	Cigna Supplemental Benefits	☐ Enrollment portal ☐ Clearinghouse	
☐ EFT only ☐ EFT and ERA	56139	Maestro Health	☐ Enrollment portal ☐ Clearinghouse	
☐ EFT only ☐ EFT and ERA	72128	Vantage Health Plans	☐ Enrollment portal ☐ Clearinghouse	
☐ EFT only ☐ EFT and ERA	43168	Advantica/Delta Dental of Missouri	☐ Enrollment portal ☐ Clearinghouse	

If you checked 'clearinghouse' above, you MUST choose one of the following clearinghouses: • Availity • Capario • Claim.MD • ClaimsNet • Emedix • Encoda • eProvider Solutions • Experian Health • GatewayEDI • Healthcare IP • HealthEWeb • InfinEDI • Inmar • Instamed • MedAssets • Navicure • Office Ally • Optum Insight • OS Inc • PNC Bank • Practice Insight • Quadax • Relay Health • Rycan • SSI • TK Software • ZirMed

Financial Institution Information

Financial Institution Account	
Financial Institution Name *	
Financial Institution Address 1 *	
Financial Institution Address 2	
Financial Institution Address 3	
City *	
State/Province *	
Zip Code/Postal Code *	
Financial Institution Telephone Number	
Telephone Number Extension	
Financial Institution Routing Number * – *must be nine numeric digits*	
Financial Institution Account Number *	
Type of Account at Financial Institution *	☐ Checking ☐ Savings
Account Number Linkage to Provider Identifier Identification Number (TIN) * (*Provider preference for grouping/bulking claim payments)*	☐ Group by Provider Tax ID Number ☐ Group by National Provider Identifier

CONTINUE ON NEXT PAGE

Voided Check Image

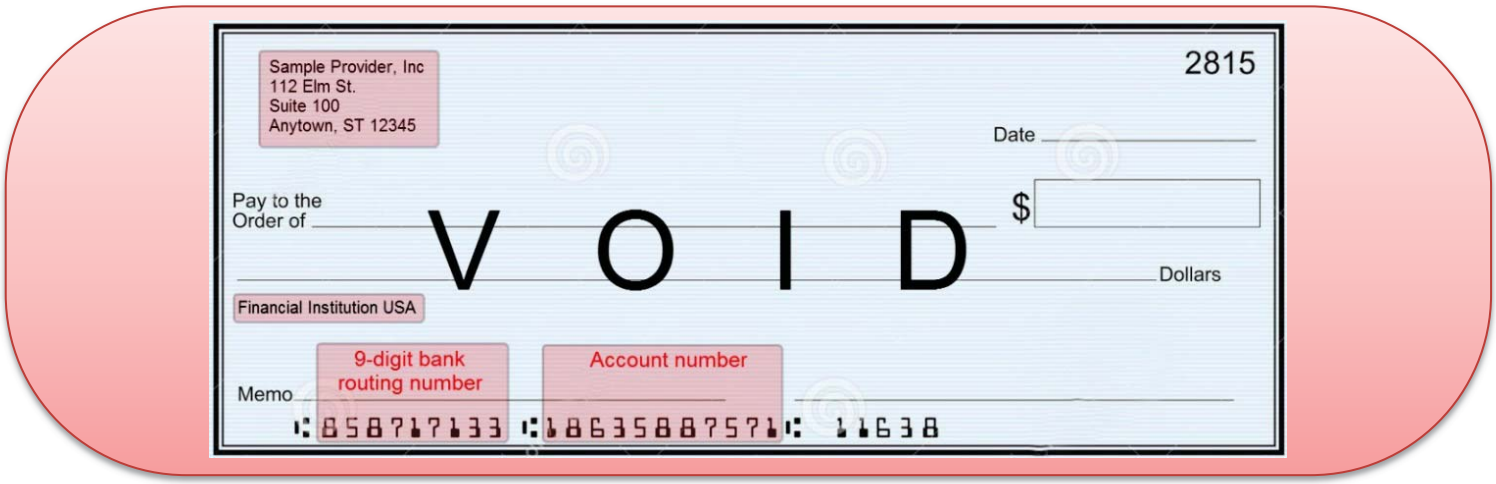
You must include a voided check in order to complete your enrollment process.

1. Be sure the **Provider name/address** is on the voided check.
2. **The Provider name/address, Financial Institution name, routing number, and account number** must match the information provided in the Enrollment Form.

- If you are using a savings account, please attach a savings account deposit slip with the routing and account number pre-printed, **not handwritten**. Handwritten deposit slips are not eligible for account verification.
- You can also attach an official signed bank letter with your Provider Name, Financial Institution routing number, Financial Institution account number, Financial Institution account type, and official Financial Institution employee signature.

If you do not have a voided check, pre-printed savings deposit slip, or official bank letter, please contact a Provider Service Representative at (844) 292-4066 or email support@ach835.com for assistance.

Place voided check below this line.



Provider EFT/ERA Enrollment Acknowledgments and Authorization

Provider confirms that all information provided to Redcard is accurate and complete. Provider authorizes Red-Card Systems, LLC or one of its Affiliates to initiate ACH debit and credit entries to the financial institution account indicated on his/her EFT Enrollment Form. Provider acknowledges that their enrollment information will be made available to the Payers making payments to Provider through the EFT/ERA Enrollment service. Provider acknowledges that the origination of ACH transactions to the financial institution account indicated on his/her EFT Enrollment Form must comply with the provisions of U.S. law. This agreement will remain in effect until Provider notifies the Payer of the desire to cancel this service, until Provider cancels this service on his/her own accord through the Enrollment portal, or until Provider is notified by the Payer that this service has been terminated. Provider understands he/she must allow reasonable time for his/her instructions to be executed.

As required by 42C.F.R. 455.18 and 455.19, Provider understands in accepting electronic payment that such payment may be from Federal and State Funds and any falsification or concealment of a material fact may be prosecuted under Federal Law.

☐ By checking this box, I acknowledge that I have read, agree with, and agree to comply with the above acknowledgments and with these Terms and Conditions for Electronic Payments and Remittance.

IN WITNESS WHEREOF, the parties have caused this Provider EFT/ERA Enrollment Acknowledgments and Authorization Form to be executed by their respective duly authorized representatives.

Submitter Name:*	
Provider TIN:*	
Submitter Signature:*	
Date:*	
Submitter Email:*	

The information below is provided for use in completing the Enrollment Form above. Fields entered above should be in conformance with CORE Operating Rule 380. The table below is taken directly from that Rule.

Table: 4.2-1 CORE-required Maximum EFT Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name (Term)**	**Data Element Description**	**Data Type and Format (Not all data elements require a format specification)**	**Data Element Requirement for Health Plan Collection (Required/ Optional for plan to collect)**	**Data Element Group Number (DEG#)**
PROVIDER INFORMATION (Data Element Group 1 is a Required DEG)					
Provider Name		Complete legal name of institution, corporate entity, practice or individual provider	Alphanumeric	Required	DEG1
Doing Business As Name (DBA)		A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it	Alphanumeric	Optional	DEG1
Provider Address				Optional	DEG1
	Street	The number and street name where a person or organization can be found	Alphanumeric	Required	DEG1
	City	City associated with provider address field	Alphanumeric	Required	DEG1
	State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country	Alpha	Required	DEG1
	ZIP Code/ Postal Code	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	Alphanumeric, 15 characters	Required	DEG1

PROVIDER IDENTIFIERS INFORMATION (Data Element Group 2 is a Required DEG)					
Provider Identifiers				Required	DEG2
	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	Numeric, 9 digits	Required	DEG2
	National Provider Identifier (NPI)	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	Numeric, 10 digits	Required when provider has been enumerated with an NPI	DEG2
Other Identifier(s)			Alphanumeric	Optional	DEG2
	Trading Partner ID	The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor	Alphanumeric	Optional	DEG2

PROVIDER CONTACT INFORMATION (Data Element Group 3 is an Optional DEG)					
Provider Contact Name		Name of a contact in provider office for handling EFT issues	Alphanumeric	Required	DEG3
	Telephone Number	Associated with contact person	Numeric, 10 digits	Required	DEG3
	Telephone Number Extension			Optional	DEG3
	Email Address	An electronic mail address at which the health plan might contact the provider		Required; not all providers may have an email address	DEG3
	Fax Number	A number at which the provider can be sent		Optional	DEG3

FINANCIAL INSTITUTION INFORMATION (Data Element Group 7 is a Required DEG)					
Financial Institution Name		Official name of the provider's financial institution	Alphanumeric	Required	DEG7
Financial Institution Address				Optional	DEG7
	Street	Street address associated with receiving depository financial institution name field	Alphanumeric	Required	DEG7
	City	City associated with receiving depository financial institution address field	Alphanumeric	Required	DEG7
	State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country	Alpha	Required	DEG7
	ZIP Code/ Postal Code	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	Alphanumeric, 15 characters	Required	DEG7

Financial Institution Telephone Number		A contact telephone number at the provider's bank	Numeric, 10 digits	Optional	DEG7
	Telephone Number Extension			Optional	DEG7
Financial Institution Routing Number		A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited	Numeric, 9 digits	Required	DEG7
Type of Account at Financial Institution		The type of account the provider will use to receive EFT payments, e.g., Checking, Saving		Required	DEG7
Provider's Account Number with Financial Institution		Provider's account number at the financial institution to which EFT payments are to be deposited		Required	DEG7
Account Number Linkage to Provider Identifier		Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice		Required; select from one of the two below	DEG7
	Provider Tax Identification Number (TIN)		Numeric, 9 digits	Optional – required if NPI is not applicable	DEG7
	National Provider Identifier (NPI)		Numeric, 10 digits	Optional – required if TIN is not applicable	DEG7
SUBMISSION INFORMATION (Data Element Group 8 is a Required DEG)					
Reason for Submission				Required; select from below	DEG8
	New Enrollment			Optional	DEG8
	Change Enrollment			Optional	DEG8
	Cancel Enrollment			Optional	DEG8
Include with Enrollment Submission				Optional; select from below	DEG8

	Voided Check	A voided check is attached to provide confirmation of Identification/Account Numbers		Optional	DEG8
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		Required; select from below	DEG8
	Electronic Signature of Person Submitting Enrollment			Optional	DEG8
	Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity		Optional	DEG8
	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		Optional	DEG8
	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		Optional	DEG8
Submission Date		The date on which the enrollment is submitted	CCYYMMDD	Optional	DEG8
Requested EFT Start/Change/ Cancel Date		The date on which the requested action is to begin	CCYYMMDD	Optional	DEG8