ERA Agreement — Submission Instructions

Important: *Submit the completed Electronic Remittance Advice (ERA) Agreement form. Call the* ***TMHP EDI Help Desk*** *at* ***1-888-863-3638*** *if you need assistance.*

Return this form to:

Texas Medicaid & Healthcare Partnership
Attention: EDI Help Desk MC–B14
PO Box 204270
Austin, TX 78720-4270

Fax to:

(512) 514-4228
OR
(512) 514-4230

By submitting a signed copy of the ERA Agreement form I agree to the following:

I (we) request to receive Electronic Remittance and Status (R&S) information and authorize the information to be deposited in the electronic mailbox as indicated below. I (we) accept financial responsibility for costs associated with receipt of Electronic R&S information.

I (we) understand that an Adobe PDF version of the paper R&S will continue to be sent to my (our) TexMedConnect account.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

As part of the ERA enrollment process and to comply with the Affordable Care Act CAQH CORE Rule 370, if you are enrolling or have previously enrolled for EFT payments, please contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements. These data elements will allow you to easily associate your EFT payment with the appropriate ERA remittance advice. You may read more about the CAQH CORE Rule at the CAQH website: **http://caqh.org/**

Only one submitter ID can download the Electronic R&S. Choosing Change Enrollment will cancel any previous Electronic R&S setup. Providers are advised to determine the current recipient of the Electronic R&S before selecting this option. Providers may use the View R&S Reports link on the TexMedConnect portal to allow multiple users to access an Adobe PDF version of the paper R&S.

Complete the required fields on the ERA Agreement form as follows:

Provider Information	
Provider name	Enter the provider's legal name according to the Internal Revenue Service (IRS).
Provider Address	Enter the provider's address including the street, city, state/province and ZIP + 4 code/postal code.
Provider Identifiers Information	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	Enter the provider's TIN or EIN.
National Provider Identifier (NPI)	Enter the provider's NPI.
Billing Taxonomy Code	The billing taxonomy code (One request form per taxonomy code is required.)
Assigning Authority	Organization that issues and assigns the additional identifier requested on the form, e.g., Medicare, Medicaid.
Trading Partner ID	Enter the submitter/production ID.

ERA Agreement — Submission Instructions

Electronic Remittance Advice Information	
Preference for Aggregation of Remittance Data	Select the provider's preference for grouping (bulking) claim payment Electronic R&S.
Method of Retrieval	Enter the method in which the provider will receive the Electronic R&S from the health plan.
Submission Information	
Reason for Submission	Select the most appropriate reason for submission of the ERA Agreement form.
Authorized Signature	
Written Signature of Person Submitting Enrollment	Signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment.
Submission Date	Enter the date the ERA Agreement form was signed.
Printed Name of Person Submitting Enrollment	Enter the printed name of the person signing the ERA Agreement form.
Printed Title of Person Submitting Enrollment	Enter the printed title of the person signing the ERA Agreement form.
Requested EFT Start/Change/Cancel Date	Enter the date on which the requested action is to begin.

Other Data Elements
The other data elements within this form will allow providers to easily associate Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) transactions. Refer to the Council for Affordable Quality Healthcare (CAQH) website, **http://caqh.org/** for more information about CORE Rule 370 and the other data elements on the ERA Agreement form.

Electronic Remittance Advice (ERA) Agreement

Provider Information					
Provider Name *				**Doing Business As Name (DBA)**	
Provider Address ***Street ****	***City ****		***State/Province ****	***ZIP + 4 Code/Postal Code ****	***Country Code***

Provider Identifiers Information	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) *	**National Provider Identifier (NPI) ***
Billing Taxonomy Code *	**Assigning Authority ***
Trading Partner ID *	**Provider Benefit Code (if applicable)**
146254604	
Provider License Number	**License Issuer**

Provider Contact Information		
Provider Contact Name		**Title**
Telephone Number	**Telephone Number Extension**	**Email Address**
Fax Number		

*** Required field**

Electronic Remittance Advice (ERA) Agreement

Provider Agent Information					
Provider Agent Name					
Agent Address ***Street***	***City***	***State/Province***	***ZIP Code/Postal Code***	***Country Code***	
Provider Agent Contact Name			**Title**		
Telephone Number	**Telephone Number Extension**		**Email Address**		
Fax Number					

Federal Agency Information	
Federal Program Agency Name	
Federal Program Agency Identifier	**Federal Agency Location Code**

Retail Pharmacy Information	
Pharmacy Name	**Chain Number**
Parent Organization ID	**Payment Center ID**
NDCP Provider ID Number	**Medicaid Provider Number**

Electronic Remittance Advice Information
Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier): *
☐ Provider Tax Identification Number (TIN):_____ ☐ National Provider Identifier (NPI): _____
Method of Retrieval

*** Required field**

Electronic Remittance Advice (ERA) Agreement

Electronic Remittance Advice Clearinghouse Information	
Clearinghouse Name	**Clearinghouse Contact Name**
Telephone Number	**Email Address**

Electronic Remittance Advice Vendor Information	
Vendor Name	**Vendor Contact Name**
Telephone Number	**Email Address**

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

Authorized Signature	
Written Signature of Person Submitting Enrollment *	
Printed Name of Person Submitting Enrollment *	**Printed Title of Person Submitting Enrollment ***
Requested ERA Effective Date *	**Submission Date ***

*** Required field**