EFT/ERA FORMS

IF YOU HAVE ANY QUESTIONS OR CONCERNS PLEASE CALL:

1-888-633-4055

EFT
FORM WALK THROUGH

The next slides will go over the EFT form

Slides (3-9)

EFT FORM

South Country Health Alliance

Electronic Funds Transfer (EFT) Authorization Agreement

Please note: If you are signing up for EFT, you must also sign up for Electronic Remittance Advice (ERA) (if not currently enrolled).

DO NOT PRINT AND SEND IN THE WEB FORM

FILL IN THIS FORM ONLINE AND PRINT THE AUTHORIZATION PAGE THAT WILL POPULATE AFTER SUBMITTING.

Provider Information

⊞ Instructions

Provider name *

Provider Name

Doing Business As (DBA) name *

DBA Name

Provider Address

Street Address *

Address

City *

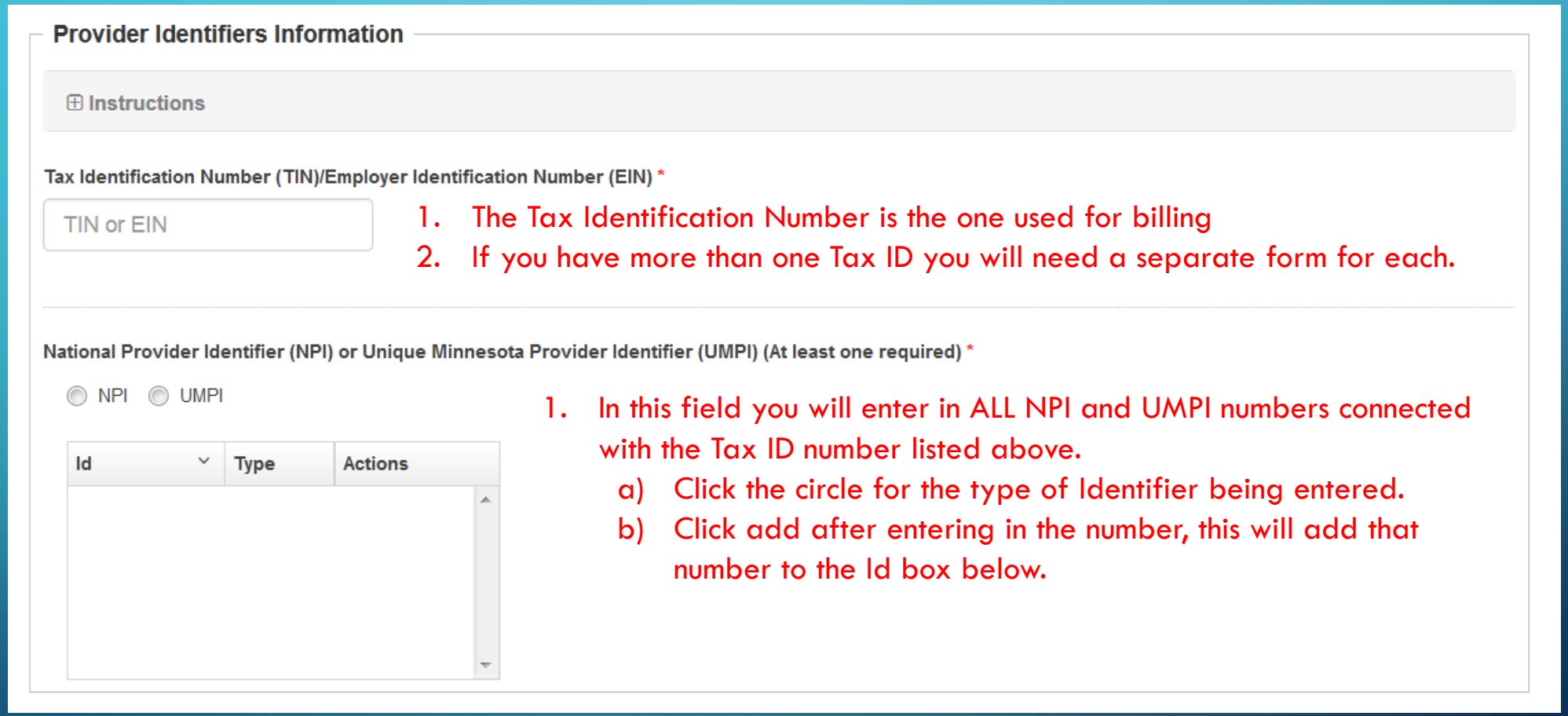
City

State/Province *

-- Select One --

Zip code/Postal code *

_____-____


Provider Identifiers Information
Instructions
Tax Identification Number (TIN)/Employer Identification Number (EIN) *
TIN or EIN
1. The Tax Identification Number is the one used for billing
2. If you have more than one Tax ID you will need a separate form for each.
National Provider Identifier (NPI) or Unique Minnesota Provider Identifier (UMPI) (At least one required) *
NPI
UMPI
Id
Type
Actions
1. In this field you will enter in ALL NPI and UMPI numbers connected with the Tax ID number listed above.
a) Click the circle for the type of Identifier being entered.
b) Click add after entering in the number, this will add that number to the Id box below.

Provider Contact Information

⊞ Instructions

This information would be either the name and contact information for the person filling out the form or the person connected with Billing/Contracting

Provider contact first name *

First Name

Provider contact last name *

Last Name

Title *

Title

Telephone number *

(___) ___-____ ext. _____

Email address *

example@domain.com

Financial Institution Information

⊞ Instructions

Financial institution name *

Institution Name

1. Please fill out all of the banking information in this section.
2. The Account number linkage is the Tax-ID number, NPI or UMPI number that you will be billing under

Financial institution Address

Street *

Address

City *

City

State/Province *

-- Select One --

Zip code/Postal code *

_____-____

Financial institution telephone number *

(___) ___-____

Financial institution routing number (9-digit) *

Type of account at financial institution *

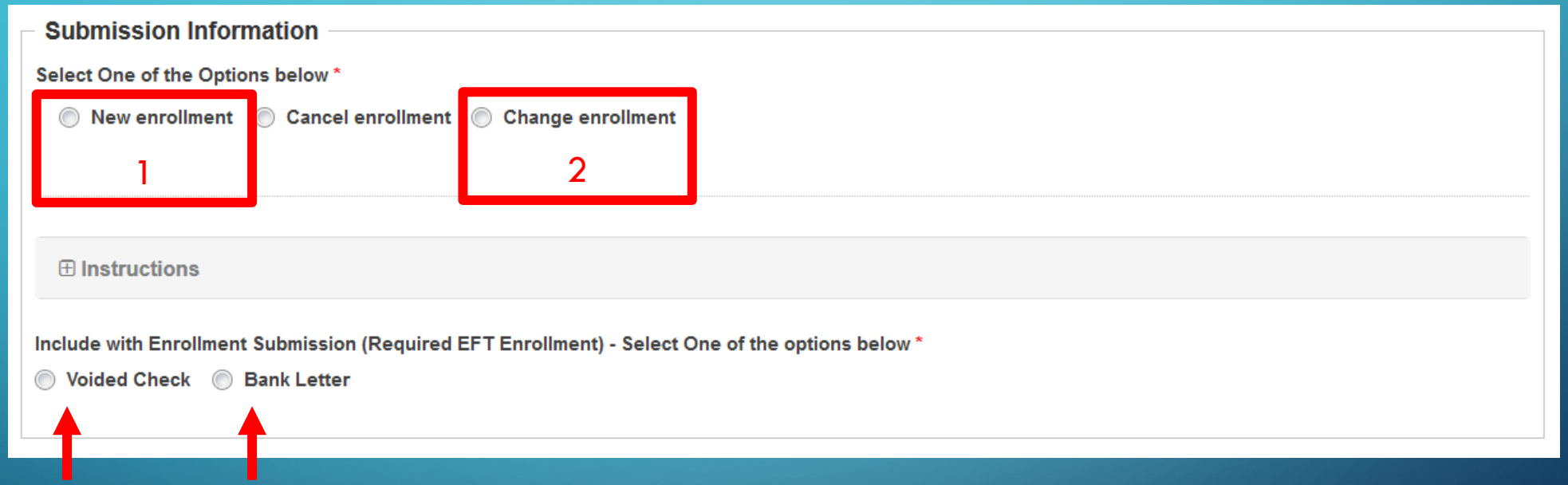
Checking Account Savings Account

Provider account number with financial institution *

Account number linkage to Provider Identifier *

-- Select TIN/NPI --

1. On this screen you will select New enrollment if you are setting up your EFT.
2. If you have made a mistake and need to correct something you can resubmit this form and select Change Enrollment
3. If you have decided you would rather have paper checks you can select the Cancel Enrollment option



1. Please select the type of document you will be submitting

2. In order to complete the process for setting up your EFT you will need to send in a Voided Check or Bank Letter with a signed authorization form which you will get after the next step

Authorization

⊞ Instructions

I affirm all of the information contained in this enrollment application to be correct and true to the best of my knowledge. I understand that providing false or misleading information on this enrollment application will result in rejection from the EFT payment program and that I will be responsible for any fees, legal or otherwise, incurred by South Country Health Alliance on my behalf. NO BALANCE BILLING TO PATIENT. By accepting South Country Health Alliance payments, you agree to only bill or attempt to collect from the member any unpaid amounts on any remittance indicated as "member responsibility."

Authorized Signature –

Please make sure this Authorization Agreement is filled out completely and Click Submit. After the form has been submitted, an Authorization Agreement signature document will display.

Print off the Authorization Agreement signature document and sign. Please mail the signed document along with a voided check or bank letter (signed and dated by a bank representative) to our office. If you have any questions about this form, send and email to schaclaims@primewest.org or call the Provider Contact Center at 1-888-633-4055 (toll free).

Mailing address:
South Country Health Alliance
Attn: Provider Network - Accts Payable
3905 Dakota Street
Alexandria, MN 56308

1. **In this section the person submitting the enrollment will fill out their information with their title.**

Name of Person Submitting Enrollment *

Title of Person Submitting Enrollment *

Requested EFT Start/Change/Cancel Date *

MM/DD/YYYY

Submit

1. The Requested EFT Start/Change date will be the date you submit the form
2. You **MUST** click Submit. After you click submit you will get to print a copy of the authorization page which you will return with the Voided check or bank letter.

EFT FORM

- After clicking Submit you will get a copy of the form that needs to be signed and submitted.
- Mail the documents to:

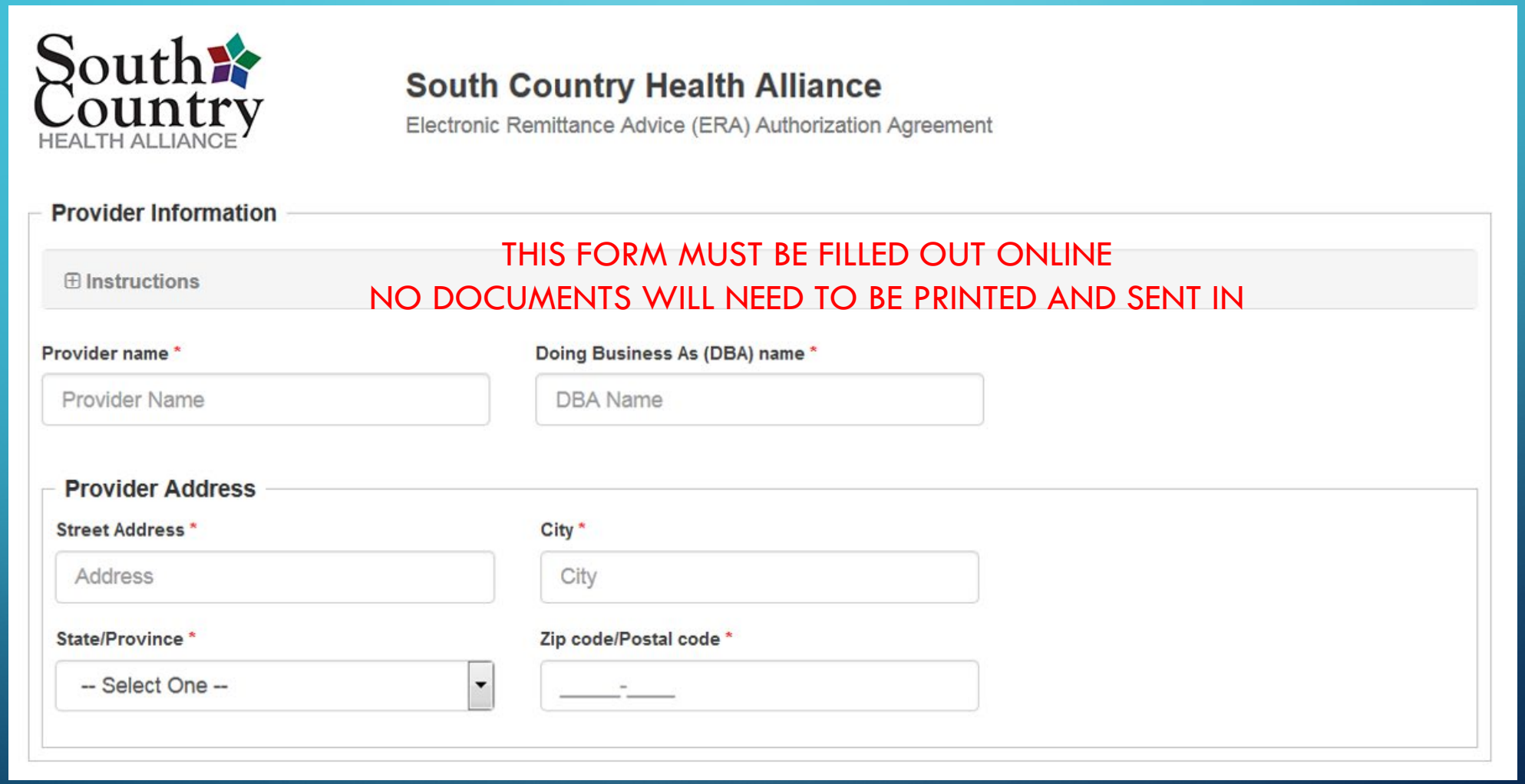
South Country Health Alliance
Attn: Provider Network - Accts Payable
3905 Dakota Street
Alexandria, MN 56308

ERA
FORM WALK THROUGH

The next slides will go over the ERA form

Slides (11-16)

ERA FORM



South Country HEALTH ALLIANCE

South Country Health Alliance

Electronic Remittance Advice (ERA) Authorization Agreement

Provider Information

THIS FORM MUST BE FILLED OUT ONLINE
NO DOCUMENTS WILL NEED TO BE PRINTED AND SENT IN

⊞ Instructions

Provider name *

Provider Name

Doing Business As (DBA) name *

DBA Name

Provider Address

Street Address *

Address

City *

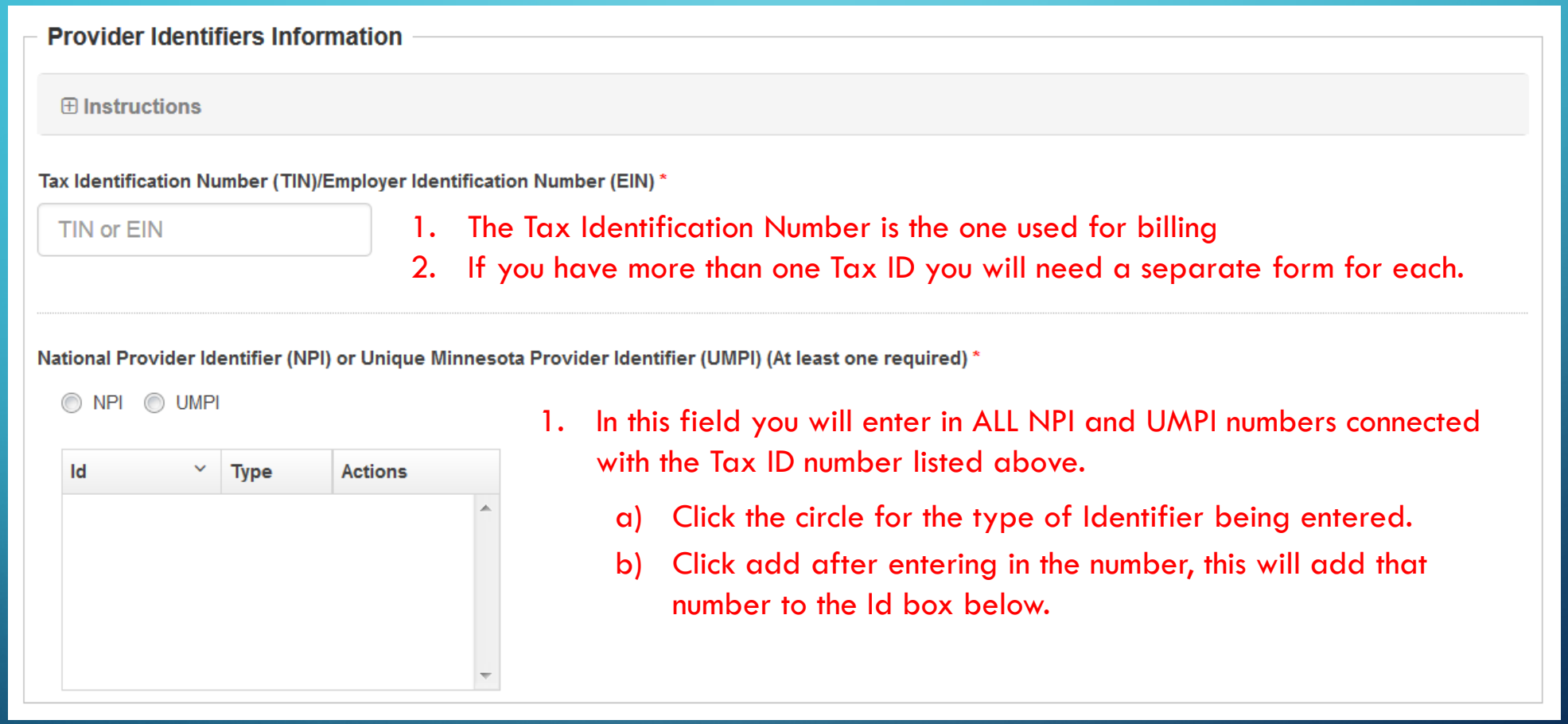
City

State/Province *

-- Select One --

Zip code/Postal code *

_____-____



1. The Tax Identification Number is the one used for billing
2. If you have more than one Tax ID you will need a separate form for each.

1. In this field you will enter in ALL NPI and UMPI numbers connected with the Tax ID number listed above.
   a) Click the circle for the type of Identifier being entered.
   b) Click add after entering in the number, this will add that number to the Id box below.

Provider Contact Information

⊞ Instructions

This information would be either the name and contact information for the person filling out the form or the person connected with Billing/Contracting

Provider contact first name *

First Name

Provider contact last name *

Last Name

Title *

Title

Telephone number *

(___) ___-____ ext. _____

Email address *

example@domain.com

Preference for Aggregation of Remittance Data

Account number linkage to Provider Identifier *

-- Select TIN/NPI --

This would be the Tax Id entered above on the form. The drop-down box will give you options based on what was entered at the top of the form.

ERA Clearinghouse Information

⊞ Instructions

Please indicate the name of the clearinghouse that you are registered with for receiving 835s by checking one of the boxes below. **Note:** Prior to submission of this Agreement, you must register with a clearinghouse to receive 835s. South Country Health Alliance cannot send 835s to your clearinghouse until you have registered.

Clearinghouse name *

-- Select One --

Please select your Clearinghouse's name from the drop-down menu.

Clearinghouse contact first name

Clearinghouse contact last name

Contact person telephone number

(___) ___-____

Email Address

example@domain.com

Submission Information

Select One of the Options below *

○ New enrollment ○ Cancel enrollment ○ Change enrollment

Select New Enrollment if you have not already filled out this form. Select Change enrollment only if you have information to correct.

Authorization

Instructions

I affirm all information contained in this enrollment application to be correct and true to the best of my knowledge. I understand that providing false or misleading information on this enrollment application will result in rejection from the ERA program and that I will be responsible for any fees, legal or otherwise, incurred by South Country Health Alliance on my behalf.

Name of Person Submitting Enrollment *

Title of Person Submitting Enrollment *

Requested ERA effective date *

MM/DD/YYYY

Submit

Please fill out all required selections.

This information is the person filling out this form.

Please Click Submit

ERA ENROLLMENT FORM

After clicking submit your form has been processed.

We do not need any documents mailed or e-mailed in along with this form.