Electronic Remittance Advice (ERA) Authorization Agreement

*Providers and clearinghouses, complete the ERA form by logging on to **www.enshealth.com**. If you need assistance with your OptumInsight user name or password, please call 866-367-9778 or open a support ticket by emailing **TSupport@enshealth.com**.*

UnitedHealthcare®

Payer

Information specific to the payer. **Required**

- Payer ID - 5-digit number that indicates the payer on the 835 transaction

Provider Identifier Information

Identifies information specific to the health care organization as well as the clearinghouse/vendor that will send the 835 to the health care organization. **Required**

- Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) - A Federal Tax IdentificationNumber, also known as an Employer Identification Number (EIN), is used to identify a business entity
- National Provider Identifier (NPI) - A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique 10-digit number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use NPIs in the administrative and financial transactions adopted under HIPAA.
- Other Identifier(s)
  - Assigning Authority - Organization that issues and assigns the additional identifier requested on the form, e.g., Medicare, Medicaid. For this enrollment, it's UnitedHealthcare
  - Trading Partner ID - The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor

Electronic Remittance Advice Clearinghouse Information

Please complete this section if the submitter is a clearinghouse. **Required if applicable**

- Clearinghouse Name - Official name of the provider's clearinghouse
- Email Address - Associated with the provider's clearinghouse

Provider Information

Identifies information specific to the health care organization (professional or institutional group). **Required**

- Provider Name - Complete legal name
- Street
- City
- State
- Zip Code

Sample Form

Provider Information					Provider Identifiers Information				Provider Contact Information				Electronic Remittance Advice Information			Electronic Remittance Advice Clearinghouse Information		Electronic Remittance Advice Vendor Information		Submission Information	
	Provider Address				Provider Identifiers		Other Identifier(s)		Provider Contact Name				Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)							Reason for Submission	Authorized Signature
Provider Name	Street	City	State/ Province	Zip Code/ Postal Code	Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	National Provider Identifier (NPI)	Assigning Authority	Trading Partner ID	Contact	Telephone Number	Telephone Number Extension	Email Address	Provider Tax Identification Number (TIN)	National Provider Identifier (NPI)	Method of Retrieval	Clearing-house Name	Email Address	Vendor Name	Email Address	Pick from: -New Enrollment -Change Enrollment -Cancel Enrollment	Printed Name of Person Submitting Enrollment
Wellness Care Clinic	123 East Main Street	Any Town	Any State	55555	123456789	1234567890	UHC	B99999999999	John Smith	123-456-7890		jsmith@ wellness. com	X		Clearing-house	Clearing-house	sjones@ clearing house. com			New Enrollment	Sue Jones

Provider Contact Information

Identifies information specific to the health care organization contact. **Required**

- Provider Contact Name
- Contact - Name of a contact in provider office for handling ERA issues
- Telephone Number
- Telephone Number Extension
- Email Address

Electronic Remittance Advice Information

Identifies information on how the 835 will be aggregated. **Required**

- Preference for aggregation of remittance data (e.g., account number linkage to provider identifier). This field is for information only - provider preference for grouping (bulking) claim payment remittance advice must match preference for electronic funds transfer (EFT) payment. The EFT enrollment form will drive the aggregation
- Provider Tax Identification Number (TIN) - Please place an X in this cell to indicate a preference to aggregate by TIN
- National Provider Identifier (NPI) - Please place an X in this cell to indicate a preference to aggregate by NPI
- Method of Retrieval - The method in which the provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.)

Electronic Remittance Advice Vendor Information

Please complete this section if the submitter is a vendor. **Required if applicable**

- Vendor Name - Official name of the provider's vendor
- Email Address - An electronic mail address at which the health plan might contact the provider's vendor

Submission Information

Indicates the reason for the submission as well as the person's name submitting the enrollment. **Required**

- Reason for Submission - Please select the submission reason from the drop-down list. The valid values are:
  - New Enrollment
  - Change Enrollment - Please complete provider information and provider identifier sections as well as any data to be changed
  - Cancel Enrollment - Please provide provider information and provider identifier sections
- 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
- 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

Doc#: UHC2038d_20130801 MS-13-634p