Magellan HEALTHCARE®

837 DIRECT SUBMIT AND 835 REGISTRATION OR TERMINATION FORM (ERA)

Electronic Remittance Advice (ERA) means receiving remittance data in an electronic form, such as the HIPAA X12.835.

This form must be completed by **individual provider applicants, provider groups, or organizations** that are requesting to submit an 837 file and receive an 835 remittance, in lieu of printed documentation. In order to be eligible, you must have a W-9 on file with Magellan* and be the owner of the Taxpayer Identification Number (TIN) under which claims are paid. This form is also used by providers to terminate the 837 and 835.

Fax the completed form to Attention: Network Data Management ERA Coordinator at 888-656-3259, or mail the completed form to:

Magellan Healthcare
14100 Magellan Plaza – MO14
Maryland Heights, MO 63043
Attn: Network Data Management ERA Coordinator

PROVIDER INFORMATION

PROVIDER NAME: _____

ADDRESS LINE1: _____

ADDRESS LINE2: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

TIN: _____ **NPI #:** _____ **MIS #:** _____

Check Type: __ Employer Identification Number (EIN) __Social Security Number (SSN) __I Tax Identification Number (ITIN)

NOTE: Groups must enroll their group number only

PROVIDER AGENT CONTACT NAME: _____

TELEPHONE#: _____ **EMAIL ADDRESS:** _____

SET-UP OPTIONS

☐ **SET UP** – Enroll the entire Tax ID. All providers who bill under the TIN enrolled will receive ERA.

ERA EFFECTIVE DATE: ____/____/____ *Cannot be earlier or more than 180 days from the date you sign this form.*

This authority shall remain in effect unless you submit a written cancellation notice to Magellan. Electronic transmissions of remittance advice will not occur until Magellan initiates a claim payment to you and a successful test is conducted between Magellan and your clearinghouse. The actual Effective Date (or Termination Date) will be assigned after this process occurs. Meanwhile, remittance advice will continue to be mailed to you.

☐ **STOP** Electronic Remittance Advice. I understand I will receive paper remittance advice when this request is processed.

ERA TERMINATION DATE: ____/____/____ *Cannot be earlier than the date you sign this form.*

AUTHORIZED SIGNATURE: _____

The person(s) signing this form must be authorized to sign on behalf of the provider receiving claims remittances.

DATE: _____

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