HOW LONG DOES PRE-ENROLLMENT TAKE?
Please allow four (4) weeks for the enrollment application process. If after five (5) weeks you do not start receiving ERA files, please contact the Provider Assistance Center (PAC) at 1-800-248-2152.

HOW DO I ENROLL?
There are 2 ways to enroll to receive Electronic Remittance Advice from Medicaid Pennsylvania.

**Option 1:** Enroll Online via the PROMIS™ Provider Portal.

Once on the login page click the EFT/ERA Enrollment tab. In order to complete the enrollment you will need the following information:

- **Submitter ID:** 245179154
- **Clearinghouse Name:** Office Ally
- **Contact Name:** Customer Service
- **Telephone Number:** (360) 975-7000 opt. 1
- **Email Address:** support@officeally.com

**Option 2:** Complete and submit the Office of Medical Assistance Programs Electronic Remittance Advice (ERA) Enrollment Application (page 6-7 of this packet).

Instructions for completing this form can be found on page 2-5 of this packet. If enrolling via the paper form original signatures are required and copies will not be accepted.

WHERE SHOULD I SEND THE FORMS?
If enrolling via the paper Electronic Remittance Advice form send the completed form to:

- HP BDCM PAMMIS
- ERA Enrollment, MS A-90
- 225 Grandview Ave
- Camp Hill, PA 17011-1712

HOW DO I CHECK STATUS?
There are 2 ways to confirm status:

**Option 1:** Providers can confirm ERA enrollment by accessing the PROMIS™ Provider Portal. Once logged in select “My Homepage” in the upper left-hand corner and then select ERA and EFT Enrollment. This page will display the ERA Enrollment status and the linked Submitter ID.

**Option 2:** Providers can also send an email to RA-835-ERA@pa.gov. In order to process the request the email must include your provider number, submitter ID 245179154, and the date the original request was submitted.
Instructions for Completing the Paper Electronic Remittance Advice (ERA) Enrollment Application

General Instructions for completing the Paper ERA Enrollment Application:

- Please type or print legibly
- Complete all fields – **Incomplete applications will not be processed**
- Use only black or blue ink to complete the application
- Please allow four (4) weeks for enrollment application to process. If after five (5) weeks you do not start receiving ERA files, please contact the Provider Assistance Center (PAC) at 1-800-248-2152.

Mail completed enrollment form to:

HP BDCM PAMMIS
ERA Enrollment, MS A-90
225 Grandview Ave
Camp Hill, PA 17011-1712

The electronic ERA enrollment application can be completed by going to the PA PROMISe™ Internet Portal at [www.promise.dpw.state.pa.us](http://www.promise.dpw.state.pa.us). On the Login page click the EFT/ERA Enrollment tab.

Provider Information:

**Provider Name:** Please provide the complete legal name of the institution, corporate entity, practice, or individual provider.

**Provider Address:**

Street: Please provide the provider’s payment address.

City: Please provide the provider’s city associated with the payment address.

State: Please provide the two (2) character code associated with the state name.

**Zip Code/Postal Code:** Please provide the five (5) or nine (9) digit assigned zip code from the Post Office.

Provider Identifiers:

**Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):** Please provide the nine (9) digit federally assigned Provider Identification number used to identify and track an individual, corporation, partnership, and any other non-business entity.

**National Provider Identifier (NPI):** Please provide the federally assigned ten (10) digit number for covered Health Care Providers.
Other Identifiers:

Assigning Authority: PA PROMIS™: Pennsylvania Medicaid.

Trading Partner ID: Please provide the assigned thirteen (13) digit Medical Assistance Identification Number. Multiple locations may be included on a single enrollment form. For larger entities please attach a separate sheet listing all locations to be set up.

Example: Provider Number  Service Location  Service Location  Service Location  Service Location

0001112220001  0002  0003  0004  0005

Assigning Authority: PA PROMIS™ EDI Unit

Trading Partner ID: Also known as the submitter ID. This represents the unique nine (9) digit ID number used to access the bulletin board system. With the unique submitter ID Clearinghouse’s and additional entities may retrieve remittance advices electronically with the Pennsylvania Medicaid bulletin board system.

Provider Contact Information:

Provider Contact Name: Please provide the name of the provider contact for any ERA issues.

Telephone Number: Please provide the telephone number including area code and if applicable extension number of the provider contact.

Email Address: Please provide the electronic mailing address to send the provider contact correspondence.

Electronic Remittance Advice Information: Please select the provider’s preference for aggregation of remittance data and specify the Provider Tax Identification Number (TIN) OR the National Provider Identifier (NPI). This data is information only. Please note that PROMIS does NOT group (bulk) payments. Failure to provide aggregation data will NOT delay application processing.

Method of Retrieval: Please select the method by which the provider will receive the ERA from the Health plan.

Electronic Remittance Advice Clearinghouse Information: (If Applicable)

Clearinghouse Name: Please provide the official name of the provider’s Clearinghouse.

Clearinghouse Contact Name: Please provide the name of the Clearinghouse contact.

Telephone Number: Please provide the telephone number of the Clearinghouse contact.

Email Address: Please provide the electronic mail address which the health plan may use to contact the provider’s Clearinghouse.

Submission Information:

Reason for Submission: Please select one from the list. New Enrollment will allow the provider to enroll for ERA. Change Enrollment will allow the provider to change an existing ERA. Cancel Enrollment will allow the provider to permanently terminate the ERA.

Authorized Signature: This is the signature of the individual authorized by the provider or their agent to initiate, modify, or terminate an ERA enrollment.
**Written Signature:** This would be a rendering signature (usually cursive) of a name unique to a particular person used as confirmation of authorization and identity.

**Printed Name of Person Submitting Enrollment:** This is the printed name of the person signing this form who is authorized by the provider or their agent to initiate, modify, or terminate an ERA enrollment.

**Printed Title of Person Submitting Enrollment:** This is the printed title of the person signing this form who is authorized by the provider or their agent to initiate, modify, or terminate an ERA enrollment.

**Submission Date:** The date on which the ERA enrollment is submitted.

**Requested ERA Start/Change/Cancel Date:** The date on which the requested action is to begin.

For questions about this form, please call the Provider Assistance Center (PAC) at 1-800-248-2152 or send an email to ra-835-era@pa.gov.

Missing/Late ERA Files: If you have not received your ERA within four (4) business days of your EFT issuance, please contact the Provider Assistance Center (PAC) at 1-800-248-2152. Requests for files older than 90 days will not be honored.
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# Electronic Remittance Advice (ERA) Enrollment Application

## Provider Information

<table>
<thead>
<tr>
<th>Provider Name</th>
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</thead>
<tbody>
<tr>
<td>Provider Address</td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State/Province</td>
<td></td>
</tr>
<tr>
<td>ZIP Code/Postal Code</td>
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</tbody>
</table>

## Provider Identifiers

<table>
<thead>
<tr>
<th>Provider Identifiers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)</td>
<td></td>
</tr>
<tr>
<td>National Provider Identifier (NPI)</td>
<td></td>
</tr>
</tbody>
</table>

## Other Identifier

<table>
<thead>
<tr>
<th>Assigning Authority</th>
<th>PA PROMIS™</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trading Partner ID</td>
<td></td>
</tr>
<tr>
<td>(13-digit Provider ID, plus any additional 4-digit Service Locations)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Assigning Authority</th>
<th>PA PROMIS™ EDI Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trading Partner ID</td>
<td></td>
</tr>
<tr>
<td>(9-digit Submitter ID for ANSI X12 v5010 Transactions)</td>
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</tbody>
</table>

## Provider Contact Information

<table>
<thead>
<tr>
<th>Provider Contact Name</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Telephone Number</td>
<td></td>
</tr>
<tr>
<td>Telephone Number Extension</td>
<td></td>
</tr>
<tr>
<td>Email Address</td>
<td></td>
</tr>
</tbody>
</table>

## Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)

*Specify either TIN or NPI. Preference will not change aggregation by PROMIS™.*

<table>
<thead>
<tr>
<th>Preference</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Tax Identification Number (TIN):</td>
<td></td>
</tr>
<tr>
<td>National Provider Identifier (NPI):</td>
<td></td>
</tr>
</tbody>
</table>
Method of Retrieval

____Clearinghouse

____PA PROMISE Provider Electronic System (PES)

____Other (please describe) ________________________________

Electronic Remittance Advice Clearinghouse Information  (If applicable)

Clearinghouse Name  Office Ally

Clearinghouse Contact Name  Customer Service

Telephone Number (360) 975-7000 opt. 1

Email Address support@officeally.com

Submission Information

Reason for Submission  (Choose one)

____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

Submission Date ____________  (format: CCYYMMDD)

Requested ERA Effective Date ____________  (format: CCYYMMDD)

Mail completed enrollment form to:

HP BDCM PAMMIS
ERA Enrollment, MS A-90
225 Grandview Ave
Camp Hill, PA 17011-1712