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## Help resources:

# Authorization Agreement for Electronic Health Care Claim Payment/Advice (835)

### Section 1: Provider information

**Provider name:** Complete legal name of institution, corporate entity, practice, or individual provider

**Street:** The number and street name where a person or organization can be found

**City:** City associated with the address

**State/Province:** State/Province associated with the address

**Zip Code:** ZIP code associated with the address

### Section 2: Provider Identifiers Information

**Identification Number:** Use the Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN). These are nine-digit identification numbers used by the Internal Revenue Service in the administration of tax laws.

**National Provider Identifier (NPI):** A unique 10-digit identification number for covered healthcare providers. The provider may list multiple NPI numbers if they share the Federal Tax ID listed in the identification number field. Complete a separate [Authorization Agreement for Electronic Health Care Claim Payment/Advice \(835\)](#) form for each unique Federal Tax ID.

### Section 3: Provider Contact Information

**Provider Contact Name:** Name of a person in the provider's office that handles ERA issues

**Title:** Title associated with contact

**Email Address:** Email address associated with contact

**Telephone Number:** Telephone number associated with the contact

**Fax Number:** Fax number associated with the contact

### Section 4: Electronic Remittance Advice Information

**Preference for Aggregation of Remittance Data:** Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFT payment

**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.)

### Section 5: Electronic Remittance Advice Clearinghouse Information

**Clearinghouse Name:** Official name of the provider's clearinghouse

**Contact Name:** Name of contact in the clearinghouse office for handling ERA issues

**Phone Number:** Phone number of contact

**Email Address:** An electronic mail address at which the health plan might contact the provider's clearinghouse

### Section 6: Electronic Remittance Advice Vendor Information

**Vendor Name:** Official name of the provider's vendor

**Contact Name:** Name of contact in the vendor office for handling ERA issues

**Phone Number:** Phone number of contact

**Email Address:** An electronic mail address at which the health plan might contact the provider's vendor

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## Section 7: Submission Information

**Reason for Submission:** Select either new enrollment, change enrollment, or cancel enrollment

### Authorized Signature

**Signature of Person Submitting Enrollment:** The signature of an individual authorized by the provider to initiate, modify, or terminate an enrollment

**Title of Person Submitting Enrollment:** The title of the person signing the form

**Requested ERA Effective Date:** Date the provider wishes to begin ERA