



Attention: Provider Enrollment  
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 Springfield, MA 01144-1500  
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 800-842-4464, option #1, x5000  
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# 835 HEALTH CARE ELECTRONIC REMITTANCE ADVICE (ERA) NEW REQUEST FORM

## Section A - Provider Information

PLEASE INDICATE YOUR CLASSIFICATION (CHECK ALL THAT APPLY)

INDIVIDUAL PROVIDER     
  GROUP/PRACTICE     
  FACILITY     
  BOTH GROUP & FACILITY

PROVIDER/GROUP NAME

PROVIDER TAX ID MULTIPLE TAX IDs (SEE ATTACHMENT 1)

PROVIDER CONTACT NAME

PROVIDER BILLING ADDRESS	CITY	STATE	ZIP
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PROVIDER CONTACT PHONE NUMBER PROVIDER CONTACT EMAIL

## Section B - Vendor Information/Clearinghouse/Billing Agent

VENDOR NAME

VENDOR CONTACT NAME VENDOR TAX ID

VENDOR CONTACT PHONE NUMBER

By checking here, Provider authorizes Health New England, Inc. to transmit Provider's 835 files to Vendor.

Provider, \_\_\_\_\_, hereby appoints  
*Provider Name/Provider Representative Name (please print)*

\_\_\_\_\_ to act as the authorized agent for  
*Vendor (please print)*

the purpose of retrieving the 835 electronically from Health New England, Inc.

## Section C - Provider Certification

The undersigned Provider, \_\_\_\_\_, hereby certifies to Health New  
*Provider Name (please print)*

England, Inc. the following with respect to the 835 Electronic Remittance Advice:

- Provider will coordinate receipt of remittance test file(s) from the designated clearinghouse/vendor if a vendor is named.
- Provider acknowledges that it will complete the test file(s) and use the 835 Remit data for posting to their accounting systems.
- Provider will notify their EDI Vendor of their intention to begin ERA testing.
- Provider agrees that upon approval of this Certification and the initiation of routine ERA processing, Provider will no longer receive hard copy EOR (Explanation of Remittance) after thirty (30) days from production.
- Provider, or an authorized representative of Provider, will notify Health New England in writing of any changes or corrections required in the ERA process.

