835 Healthcare Electronic Remittance Advice (ERA) Request/Certification Form

envolve™ Pharmacy Solutions

General Instructions

This form is designed for providers who want to receive a HIPAA X12N 835 version 5010 A1 electronic remittance (ERA) transaction (Raw Data File) from Envolve Pharmacy Solutions. It is recommended that auto-posting software or a translator be used to view the X12 file.

Form must be completed IN FULL. Please type or print clearly.

A. Pharmacy Provider Information (To be completed by the pharmacy provider office)

Provider Classification: | Individual Provider Group/Practice Facility Other _____

Provider/Group Name:	Provider Contact Name:
Provider Business Address:	Provider City/Stat/Zip:
Provider Contact Phone:	Provider E-mail Address (Required):
Provider Tax ID / NCPDP #:	Multiple Tax IDs (check if applicable and see Attachment 1):	Yes	No

B. TPA/Billing Agency Information

Instructions: This section is for the vendor that supports your electronic remittance advice software and/or delivers the 835 Health Care Electronic Advice to you.

Type of service used to receive electronic transactions (835):

TPA Billing Agency (BA)

If using a Billing Agency, complete section B.1 only. If using a TPA, complete Sections B.1 and B.2.

B.1: Completion Required. The TPA/Billing agency must complete this section.

TPA/BA Name:	Contact Name:	
Contact Phone:	Contact E-mail Address:	Contact Fax Number:

B.2: Complete if using a TPA.

TPA (if 835s not delivered)		
Contact Phone:	Contact E-mail Address:	Contact Fax Number:

C. Authorization Signature

Pharmacy Provider, _____ hereby appoints _____
(Pharmacy Provider Rep. Name (please print)) (Billing Agent/TPA (Please Print))

to act as the authorized agent for the purpose of retrieving the 835 electronically from Envolve Pharmacy Solutions

Pharmacy Name/Representative (print below):

Pharmacy Name/Representative (sign below):	Date:

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D. Healthcare Provided Certification
The undersigned Pharmacy Provider _____ hereby certifies to Envolve Pharmacy Solutions the following with respect to the 835 Electronic Remittance Advice:
OPTION#1: I would like to test my ERA file for 30 days: ▪ Pharmacy provider will coordinate receipt of remittance test file(s) from the designated TPA/vendor. ▪ Pharmacy provider acknowledges that they complete the test file(s) and use the 835 Remit data for posting to their accounting systems. ▪ Pharmacy provider will notify their EDI TPA of their intention to begin ERA testing. **Note: After 30 days of testing, most paper EOB's will no longer be received.**
OPTION#2: I would like to start receiving my ERA file upon setup without testing: ▪ Pharmacy provider will start receiving and processing Envolve Pharmacy Solutions Electronic Remittance Advice (ERA) information ▪ Pharmacy provider agrees upon approval of this certification and initiation of routine ERA processing, Organization will (as applicable): ▪ No longer receive Envolve Pharmacy Solutions hard copy Remittance Advice for claims processed on the Envolve Pharmacy Solutions system and will solely rely on the ERA file for all Remittance Information ▪ Pharmacy provider or an authorized representative of the Pharmacy organization will notify Envolve Pharmacy Solutions in writing of any changes or corrections required in the ERA process. **Note: Most paper EOB's will no longer be received.**

Approved by:	
Authorized Representative (sign below):	Title:
Printed Name:	Date:

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Attachment 1: For Providers with Multiple Tax IDs OR NCPDP #s (Please use one or the other)	
If you receive reimbursement for multiple Tax IDs, please list them below. If you prefer to receive the 835 health care electronic remittance advice (ERA) for one Tax ID, please ensure that Tax ID is placed in section A.	
Facility Name/Group Name/Practice Name/Pharmacy Provider name	**Tax ID OR NCPDP #**