



Empowering Healthcare

ERA Payer Agreement Instructions for Great-West Healthcare – Payer ID 80705

Important Notes

ERA transactions are available as an additional McKesson contracted service. To add ERAs to your contract please contact your McKesson Sales person or Value Added Reseller. ERAs must be part of your McKesson contract BEFORE requesting ERA service through the McKesson EDI Enrollment Department.

Electronic Funds Transfer (EFT) is an arrangement between the Physician/Provider and the Payer. McKesson does not manage or transmit EFTs.

Before receiving ERAs for Great-West the Physician/Provider must:

- Be processing claims electronically with this payer
- Contract with McKesson for All Payer ERA service
- Complete an ERA Enrollment Request Form
- Complete Great-West's Electronic Remittance Advice and Electronic Funds Transfer Enrollment Form.

Guidelines for completing: Great-West Electronic Remittance Advice and Electronic Funds Transfer Enrollment Form:

- Complete all required fields
- Submit one ERA/EFT Payer Agreement for each Physician/Group Tax ID.
- Once the agreement is open in Adobe Reader you can type information onto the form.
- Forward original ERA agreement along with your McKesson ERA Enrollment Request Form to the Enrollment Team for processing.
- Please allow up to 30 days for approval and receipt of Great-West ERA.

Fax completed Great-West ERA Agreement and McKesson ERA Enrollment Request Form to:

McKesson EDI Enrollment

800-633-4763



INPUT SHEET FOR ERA PROVIDERS
ELECTRONIC DATA SERVICES

New ERA User: X

VENDOR INFORMATION

Vendor/Billing Service Name: MedAvant Healthcare Solutions

Address: 1901 E. Alton Ave., Suite 100

City/State/Zip: Santa Ana, CA. 92705

Contact Name/Phone #: Enrollment Dept. (800-792-5256) opt. 1

ERA INFORMATION

Submitter/Receiver ID: GWH PAYOR ID'S 63665 -or- 80705 PROXY-MED RECEIVER ID 650202059

Provider Name: _____

Provider Tax ID Number: _____

Provider Address: _____

City/State/Zip: _____

Contact Name/Phone #: _____

The version to be remitted to you is HIPAA 835 4010A1

Please return completed form to:

Proxy-Med
ATTN: Enrollment Dept.
1901 E. Alton Ave., Suite 100
Santa Ana, CA 92705
Fax # (404) 877-3324

Due to HIPAA requirements, only one receiver ID per provider number may be established for ERA. The receiver ID on this request will be the only recipient of ERA for the provider numbers listed above.

Requester's Printed Name: _____

Requester's Signature: _____

Date: _____