MAGELLAN HEALTH SERVICES
Getting Better All the Time™

ELECTRONIC REMITTANCE ADVICE REGISTRATION OR TERMINATION FORM (ERA)

(Electronic Remittance Advice means receiving remittance data in an electronic form, such as the HIPAA X12.835.)

This form must be completed by individual provider applicants, provider groups, or organizations that are requesting that claims remittance (Explanation of Benefits and Explanation of Payments) be sent electronically, in lieu of printed documentation. In order to receive electronic claims remittance, you must have a W-9 on file with Magellan* and be the owner of the Taxpayer Identification Number (TIN) under which claims are paid. This form is also used by providers to terminate electronic claims remittance.

Please fax the completed form* to one of the clearinghouses listed below. They will contact Magellan when your request has been processed by them.
* For THIN, please visit their website.

PROVIDER INFORMATION

PROVIDER NAME: _____

ADDRESS LINE 1: _____

ADDRESS LINE 2: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

TELEPHONE #: _____

BILLING CONTACT NAME: _____

TIN: _____ **MIS #:** _____ **NPI #:** _____

Check Type:
- ☐ **Employer Identification Number (EIN)**
- ☐ **Social Security Number (SSN)**
- ☐ **I Tax Identification Number (ITIN)**

NOTE: **Groups must enroll their group number only**

ERA ELECTION INFORMATION

PLEASE FAX TO THE CLEARINGHOUSE BELOW WITH WHICH YOU ARE OR WILL BE ENROLLED:

NaviMedix	PayerPath	MedAvant (ProxyMed)	THIN	Emdeon (WebMD)
Fax# 505-982-3904 Attn: Jen Pacheco	Fax# 804-545-1636	Fax# 770-885-4559	www.thinedi.com	Fax# 615-231-4843

Providers must register with one of the Magellan-preferred clearinghouses above to guarantee delivery of files. Providers registering with another clearinghouse will be responsible for ensuring delivery of their files.

☐ I request that claims remittances be sent electronically through the clearinghouse identified above.

ERA EFFECTIVE DATE: ____/____/____ *Can not be earlier or more than 180 days from the date you sign this form.*

This authority shall remain in effect unless you submit a written cancellation notice to Magellan. Electronic transmissions of remittance advice will not occur until Magellan initiates a claim payment to you and a successful test is conducted between Magellan and your clearinghouse. The actual Effective Date (or Termination Date) will be assigned after this process occurs. Meanwhile, remittance advice will continue to be mailed to you.

☐ **STOP** Electronic Remittance Advice. I understand I will receive paper remittance advice when this request is processed.

ERA TERMINATION DATE: ____/____/____ *Can not be earlier than the date you sign this form.*

AUTHORIZED SIGNATURE: _____

The person(s) signing this form must be authorized to sign on behalf of the provider receiving claims remittances.

DATE: _____

*Magellan Behavioral Health, Inc., Magellan Behavioral Health Systems, LLC, f/k/a Human Affairs International, CMG Health, Inc., Green Spring Health Services, Inc., Merit Behavioral Care and their respective affiliates and subsidiaries are affiliates of Magellan Health Services, Inc. (collectively "Magellan").