



Empowering Healthcare

**ERA Payer Agreement Instructions for Superior Health Plan Texas  
Payer ID 39188**

*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 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

**Guidelines for completing enrollment for Superior Health Plan 39188**

- Superior Health Plan Texas requires that you complete the attached EDI enrollment form to add ERA
- Please note that if you enroll with ERA and ETF your paper EOB's will discontinue after 60 days

Mail the original Provider Authorization and MedAvant ERA enrollment request forms to:

**McKesson Corp.  
C/O Phoenix EDI Enrollment  
5995 Windward Pky  
Alpharetta, GA 30005**

Estimated ERA enrollment activation for this payer is fourteen days.





## ELECTRONIC FUNDS TRANSFER AGREEMENT

Providers who receive payment of claims by Superior HealthPlan must agree to the following terms and conditions:

1. **EFT Information.** Provider will submit EFT information noted below that includes the name of the entity listed on your W-9 (“Payee”), name of the bank, bank routing number, bank account number to which funds will be transferred. Provider will notify Superior in writing at least ten (10) days in advance of any changes in Payee, Payee’s name or address, or bank account name or number.
2. **Non-Provider Payee.** If the Payee indicated on the EFT information below is different from the contracted Provider and/or Group Practice, Provider must submit to Superior a signed and notarized Power of Attorney for Payee. Designation of a Payee other than Provider shall not relieve Provider of any liability for acceptance of medical assistance payments under the Medicaid program. Provider acknowledges and agrees that Payee is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable. Any payments to the Payee shall be related to the cost of processing, and shall not be based on the percentage of amounts paid or upon collection of the payments.
3. **Payment of Funds.** Provider authorizes Superior to credit and debit the proper account to Payee’s bank pursuant to an EFT and is sufficient to show acceptance of payments. Provider certifies by such acceptance that Provider submitted the claims for the services shown on the explanation of payment issued by Superior, and that the services were rendered by or under the supervision of Provider. Superior may elect for good cause to substitute payment by paper check for EFT until the cause requiring the substitution has been satisfied as determined by Superior. Payment by check will be made to the address for payments on record with Superior.
4. **Termination.** Breach of these terms may cause termination of EFT by Superior. Provider’s termination of network participation for any reason will terminate EFT automatically.

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Signature of Provider or Administrator

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Date



ELECTRONIC FUNDS TRANSFER AGREEMENT

Payee Name: \_\_\_\_\_

Payee Phone Number: \_\_\_\_\_

IRS#: \_\_\_\_\_

Bank Name: \_\_\_\_\_

Bank Address: \_\_\_\_\_

Bank City, State & Zip: \_\_\_\_\_

Bank Routing #: \_\_\_\_\_ Bank Account #: \_\_\_\_\_

EFT

- Yes, please send electronic funds transfer to the account listed above
No, please send a paper check

835

- Yes, please send electronic explanation of payment
Clearinghouse Name:
Clearinghouse ID#:
Sender/Receiver ID: (direct claim submitters only)
Technical Contact Name: Phone #:
No, please do not send an electronic explanation of payment

Remit

- Yes, please send a paper copy of the explanation of payment
No, please do not send a paper copy of the explanation of payment

If you answer yes to both "835" and "Remit", the paper copy will discontinue after 60 days.

Return form to: Superior HealthPlan
2100 South IH 35, Suite 202, Austin, TX 78704
Fax number: 1-512-692-1436

For Internal Use Only:

Table with 4 columns: SHP rcvd, Payee #, Finance, SHP