

Electronic Payment and Remittance Enrollment Form

MercyOne Health Plan offers Electronic Payment and Remittance to providers who submit their claims electronically.

Enrollments are processed within 5 business days from receipt of the completed and legible form. Once setup is complete, the primary contact on the application will receive an email indicating the effective date.

If you have questions on how to complete this form, please contact our Provider Service Center at **1-800-991-9907**, Monday – Friday from 8:00 a.m. to 5:00 p.m.

Submit completed form via fax to: **1-614-234-8673** OR return this completed form to:
MercyOne Health Plan, Attn: Network Operations, 3100 Easton Square Place, Suite 300, Columbus, Ohio 43219. You can also email this form to medigoldpdm@mchs.com.

Organization Information

Check ONE

New Enrollment **Changes to Existing Enrollment** **Cancel Existing Enrollment**

Organization Name

Remit Address	City
State	Zip
Physical Address (if different from remit)	City
State	Zip
Group Tax ID Number (TIN)	Group National Provider Number (NPI)

Check ONE Clearinghouse

Please check one and ensure your clearinghouse is set up to receive 835 files from Claimsnet prior to submission of this form.

Change Healthcare **Claimsnet**

Person Completing this Form

First Name	Last Name
Phone Number	Email Address

Designation of Depository

Bank Name	
Address	City
State	Zip
Account Number	Routing Number
Account Type <input type="checkbox"/> Checking <input type="checkbox"/> Savings	

Providers must proactively contact the financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation of the EFT payment with the ERA remittance advice.

Authorization

The person/organization above authorizes MercyOne Health Plan, through its affiliate PNC Bank, to make electronic payments to the checking account at the depository financial institution (depository) named above for services performed under the network participation agreement between the person/organization named above and MercyOne Health Plan and its affiliates. Such payments shall be made through the regional automated clearinghouse (ACH) associations, subject to the operating rules of the National Automated Clearinghouse Association. This authorization is to remain in full force and effect until MercyOne Health Plan has received written notice from the person/organization of its termination, allowing us reasonable opportunity to act on it, but in no event later than thirty (30) days advance notice. Revocation will not apply to transactions initiated before the effective date of such revocation. MercyOne Health Plan may cease providing any or all of the services upon notice to the primary contact named above. The person/organization identified above certifies that the above information is true and accurate in all respects and will promptly notify MercyOne Health Plan of any changes to the information set forth on this form.

Authorized Signature Required

Printed Name	Title
Signature	Date

CONFIDENTIALITY NOTICE: The information contained in this message, as well as all accompanying documents, constitutes confidential information that belongs to MercyOne Health Plan (HMO/PPO). This information is intended only for the use of the individual or entity named above. If you are not the intended recipient of this information, you are hereby notified that any disclosure, copying, distribution, or taking of any action in reliance on this information is strictly prohibited. If you have received this message in error, please notify the sender immediately by calling 614-546-3794. For more information, please call Member Services at 1-800-240-3851 (TTY 711).