Saint Alphonsus Health Plan
A Member of Trinity Health

3100 Easton Square Place
Suite 300
Columbus OH 43219
Phone: 800-240-3851
Fax: 833-256-2871

Electronic Payment and Remittance Enrollment Form

Saint Alphonsus 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:
Saint Alphonsus 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**

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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
☐ **Checking** ☐ **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 Saint Alphonsus 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 Saint Alphonsus 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 Saint Alphonsus 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. Saint Alphonsus 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 Saint Alphonsus Health Plan of any changes to the information set forth on this form.

Authorized Signature Required

Printed Name

Title

Signature

Date