

## Electronic Payment and Remittance Enrollment Form

Mount Carmel MediGold 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:  
**Mount Carmel MediGold, 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

<b>First Name</b>	<b>Last Name</b>
<b>Phone Number</b>	<b>Email Address</b>

## Designation of Depository

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

**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 Mount Carmel MediGold, 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 Mount Carmel MediGold 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 Mount Carmel MediGold 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. Mount Carmel MediGold 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 Mount Carmel MediGold of any changes to the information set forth on this form.

## Authorized Signature Required

<b>Printed Name</b>	<b>Title</b>
<b>Signature</b>	<b>Date</b>

CONFIDENTIALITY NOTICE: The information contained in this message, as well as all accompanying documents, constitutes confidential information that belongs to Mount Carmel MediGold (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).