EFT / ERA Companion Document Supplemental Guide

ECHO Health, Inc (ECHO®). uses several forms of security when processing EFT/ERA enrollments to protect providers from fraudulent enrollments and ensure that ECHO Health, Inc. directs funds to the appropriate party. We may ask you to supply additional information after your initial submission as part of this process. While not required at this time, supplying a voided check or certified bank letter from your financial institution will help with our enhanced verification process, should it be necessary.

Instructions and Verification Section:

Here you will find basic instructions on completing the form, including acceptable submission methods.

Payer/Insurance Company Name:

Specify only one payer for completing this form. You may submit multiple forms, but each must have the payer listed.

ECHO® Draft Number:

To protect providers, we require that the submitter prove they can access previous payments issued to the provider. The draft number will be a 9 or 10-digit number assigned to a payment issued by ECHO Health, Inc. ECHO Draft Numbers, also know as EPC Draft Numbers, can be located on paper Explanations of Payments (EPPs), typically above the first claim on your EPP. If you receive paper check payments from any payer with ECHO Health, Inc., it is also the check number. **Note**: **Draft not required for ERA enrollment only.**

Please Note: The ECHO Draft Number identifies the provider, not the payer. you can use an ECHO draft number issued within the last 180 days from any payer; the payment doesn't need to be related to the payer referenced above.

ECHO Draft Amount:

The ECHO Draft amount is the entire payment amount, not a claim or payer check number total. The check amount on a paper check will be the draft amount.

Section 1 – Form Selection:

EFT/ERA:

Most providers will select this option, which will allow them to specify directions for both the ACH payment and the entity that will receive the 835 files.

EFT Only:

This option will allow providers to specify directions for ACH payments and default the provider to our Provider Portal, https://www.ProviderPayments.com, to retrieve 835 files and PDF copies of their EPP.

ERA Only:

This option will default the provider to the existing payment preference on file and direct 835 files to the entity of their choice.

Section 2 – Provider information:

Provider Name:

Supply the legal name for the Tax ID you are enrolling. The Tax ID (TIN) should be consistent with the name listed on your IRS W-9 form.

Provider Demographics (Street, City, State, Zip):

Supply the information consistent with your W-9 form.

Section 3– Provider Identifiers Information:

Provider TIN or EIN:

This field is the primary identifier for directing payments, as it is a required field for all payers to supply when issuing payments through ECHO Health, Inc.

Provider NPI:

The NPI yes/no and NPI fields are optional, as not all payments supplied by payers provide an NPI. The NPI on the standard form will not be used to direct payments.

Please Note: If you would like to complete your enrollment and direct payments under a TIN based on specific NPIs within the TIN, contact our EDI team and indicate you would like to an NPI-based enrollment. You can contact our EDI team by calling 888.834.3511, or you can email the EDI team at EDI@echohealthinc.com.

Sections 4 & 4a – Provider Contact Information:

Provider Contact Name, Phone, Email:

In section 4, provide the contact person name, phone, and email we should reach out for issues with EFT; in section 4a, provide the contact person we should reach out to for issues with ERA. you can list the same peron, but some offices handle ACH and ERA processes separately, and you may designate a separate contact for each.

Sections 5 & 5a – Provider Agent Information *(optional)*

Provider Agent Name, Phone, Email:

Most providers do not complete sections 5 & 5a on enrollment forms. Complete this section if you designate a separate agent outside your practice to handle EFT/ERA questions and issues. In section 5, provide the contact person name, phone and email address we should reach out to for problems with EFT; in section 5a, give the contact person we should reach out to for issues with ERA. The contact can be the same person, but some offices handle ACH and ERA processes separately, and you may designate a separate contact for each.

Section 6 – Financial Institution Information *(Only required if you selected EFT or EFT/ERA):*

Financial Institution Name:

Provide the name of the bank or financial institution you are setting up for ACH deposits.

Financial Institution Routing Number:

Provide the 9-digit routing number for the financial institution you set up for ACH payments. Make sure you supply the routing number specific to ACH payments. Some institutions have separate routing numbers for wire transfers; providing a wire transfer routing number will cause your enrollment to fail.

Type of Account at Financial Institution:

Provide the type of accout you would like to set up for ACH payments. Typically, this will be a checking or savings account.

Account Number at Financial Institution:

Provide the account number for the account you would like to set up for ACH payments. When completing the field, you may supply leading zeros if your bank lists your account with leading zeros, but typically, they are not required for ACH payments.

Account Number Linkage:

Select the provider TIN radio button unless you have already contacted our ECHO Health, Inc. EDI team and you are completing an NPI-based enrollment.

Section 7 – ERA Information:

Provider TIN/NPI:

Use the same information you used when completing section 3.

Method of Retrieval:

Provide the method you will use to access 835/ERA information. Enter "clearinghouse" if you use a third-party service that will post your 835/ERA data. Enter "portal" if you use ECHO Health, Inc.'s Provider Portal, https://www.ProviderPayments.com.

Section 8 – ERA Clearinghouse Information:

This section is required only if you entered "clearinghouse" in section 7 under the retrieval method.

Clearinghouse Name:

Provide the name of the company you use for clearinghouse services.

Clearinghouse Contact Name:

Provide a specific contact you work with or the designated payer contact at the clearinghouse. If you do not have a particular person, you can enter "customer service" or the department in charge of payer support.

Clearinghouse Telephone Number:

Provide the best contact phone number for the specific contact or department indicated in **Clearinghouse Contact Name**.

Clearinghouse Email Address:

Provide the best email address for the specific contact or department indicated in **Clearinghouse Contact Name**.

Section 9 – ERA Vendor Information *(optional):*

This field is not required, but some providers use a software vendor to process ERA data through a clearinghouse automatically, and some clearinghouses also offer posting services as an additional offering. You may provide their information in this section.

Vendor Name:

Provide the name of the company you use for vendor services.

Vendor Contact Name:

Provide a specific contact you work with or the designated payer contact at the vendor. If you do not have a particular person, you can enter "customer service" or the department in charge of payer support.

Vendor Telephone Number:

Provide the best phone number for the specific contact or department indicated in the **Vendor Contact Name**.

Vendor Email Address:

Provide the best email address for the specific contact or department indicated in the **Vendor Contact Name**.

Section 10 – Submission Information:

Reason for Submission:

Choose the **New Enrollment** if this is the first time you submit enrollment for the paper identified at the beginning of the form. Choose **Change Enrollment** if you if you are updating an existing enrollment. Choose **Cancel Enrollment** if you submit the form to remove your enrollment already on file.

Printed Name of Person Submitting Enrollment:

Provide the name of the person submitting the enrollment form.

Submission Date:

This field captures the date the form is signed and submitted. It is not an enrollment start date. Providing a future date will invalidate your submission and require you to complete a new enrollment form.

Authorized Signature:

The submitter must check the box, indicating they are an authorized representative for the provider and agree to the terms and conditions governing the EFT/ERA processes under ECHO Health, Inc. Failure to check this box or refusal of the terms and conditions will result in a rejection of the enrollment form.

Signature of Person Submitting Enrollment:

Sign the form before submitting your enrollment. If you are completing the form online or using the fillable PDF, you may type your signature; you do not need to print the form.

Submission Instructions:

Be sure to sign the form. Postal mail completed form ***OR*** submit it via the ECHO Secure Portal.

Postal mail: ECHO Health, Inc., 810 Sharon Drive, Westlake, Ohio 44145.
ECHO Secure Portal: https://edi.echohealthinc.com/new-ticket.