



837 DIRECT SUBMIT AND 835 REGISTRATION OR TERMINATION FORM (ERA)

Electronic Remittance Advice (ERA) means receiving remittance data in an electronic form, such as the HIPAA X12.835.

This form must be completed by **individual provider applicants, provider groups, or organizations** that are requesting to submit an 837 file and receive an 835 remittance, in lieu of printed documentation. In order to be eligible, you must have a W-9 on file with Magellan* and be the owner of the Taxpayer Identification Number (TIN) under which claims are paid. This form is also used by providers to terminate the 837 and 835.

Please fax the completed form to the attention of Network Data Management ERA Coordinator at 1-888-656-3259, or mail the completed form to:

Magellan
PO Box 1899 – MO14
Maryland Heights, MO 63043
Attn: Network Data Management ERA Coordinator

PROVIDER INFORMATION

PROVIDER NAME: _____

ADDRESS LINE1: _____

ADDRESS LINE2: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TIN: _____ NPI #: _____ MIS #: _____

Check Type: Employer Identification Number (EIN) Social Security Number (SSN) I Tax Identification Number (ITIN)

NOTE: Groups must enroll their group number only

PROVIDER AGENT CONTACT NAME: _____

TELEPHONE#: _____ EMAIL ADDRESS: _____

I request that claims remittances be sent electronically to me.

ERA EFFECTIVE DATE: ____/____/____ *Cannot be earlier or more than 180 days from the date you sign this form.*

This authority shall remain in effect unless you submit a written cancellation notice to Magellan. Electronic transmissions of remittance advice will not occur until Magellan initiates a claim payment to you and a successful test is conducted between Magellan and your clearinghouse. The actual Effective Date (or Termination Date) will be assigned after this process occurs. Meanwhile, remittance advice will continue to be mailed to you.

STOP Electronic Remittance Advice. I understand I will receive paper remittance advice when this request is processed.

ERA TERMINATION DATE: ____/____/____ *Cannot be earlier than the date you sign this form.*

AUTHORIZED SIGNATURE: _____
The person(s) signing this form must be authorized to sign on behalf of the provider receiving claims remittances.

DATE: _____

*In California, Magellan does business as Human Affairs International of California, Inc. and/or Magellan Health Services of California, Inc.–Employer Services. Other Magellan entities include Magellan Healthcare, Inc. f/k/a Magellan Behavioral Health, Inc.; Magellan Behavioral Health of Florida, Inc.; Magellan Behavioral of Michigan, Inc.; Magellan Behavioral Health of Pennsylvania, Inc.; Magellan Providers of Texas, Inc.; and their respective affiliates and subsidiaries; all of which are affiliates of Magellan Health, Inc. (collectively “Magellan”).