



## Electronic Payment and Remittance Advice Application

This application constitutes agreement between Neighborhood Health Plan of Rhode Island and its affiliated professional or institutional provider, as identified below, to accept direct deposit of claim payment to provider's bank. Direct deposit will be made through Bank of America's Automated Clearing House to begin with first payment after the core system implementation date at the account and bank routing address indicated below.

Professional or institutional providers equipped to accept electronic remittance advices are requested to enter their transmission preference in the box provided below.

Neighborhood Health Plan of Rhode Island supports transmission of electronic remittances in ASC X12 835

version 4010A1 format, or e-mail with secure PDF retrieval via weblink. By providing e-mail address below, provider warrants that electronic transmission of the remittance advice via PDF download will be accessed in a HIPAA-compliant, secure destination with handling by authorized personnel only. If ASC X12 835 transmission is currently sent to provider, indicate below. Submission of this completed application to Neighborhood Health Plan of Rhode Island at 299 Promenade Street, Providence, RI 02908 enables participation in Neighborhood's electronic claim payment and remittance advice transmission processes. Providers will be contacted prior to implementation date for transmission testing if necessary.

IDENTIFICATION AND BANK ROUTING INFORMATION															
Business Name – check: <input type="checkbox"/> new or <input type="checkbox"/> revised application										Neighborhood Vendor ID #					
Address						City				State		Zip			
						NPI #									
Bank Name – indicate: <input type="checkbox"/> Checking or <input type="checkbox"/> Savings						TIN #									
ACH Bank Routing Number [please verify w/bank]															
Bank Account Number [no dashes]															
Authorized Bank Signatory (Provide signature here)										Date					
Authorized Bank Signatory (Print name here)															
INDICATE WHO WILL RECEIVE THE ERA FILE															
<input type="checkbox"/> Provider				<input type="checkbox"/> Billing Company				<input type="checkbox"/> Clearinghouse				<input type="checkbox"/> Other (please specify)			
MEDIA TRANSMISSION TYPE (SELECT ONE)															
<input type="checkbox"/> ASC X12 835				<input type="checkbox"/> Secure E-mail				<input type="checkbox"/> No change, I currently receive an 835 file							
RECEIVER INFORMATION															
Contact Name (Provider or Billing Co.)															
Authorized E-mail Address (Provider or Billing Co.)															
Telephone Number (Provider or Billing Co.)															
SUPPLIER AUTHORIZATION															
Authorized Provider Signature (Signature Required Below)										Date					
Authorized Provider (Print name here)															