Print Form

TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29021-7039
Fax 803-462-3986

Toll-Free: 1-800-403-3950
www.myTRICARE.com by PGBA

Nurse/Anesthesiologist Assistant
Provider Application Package

TRICARE®
NURSE / ANESTHESIOLOGIST ASSISTANT PROVIDER APPLICATION

Please submit the completed application package to:

Fax:
803-462-3986

or

Mail to:
TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29021-7039

Note: TRICARE non-network provider data management will not reply to successful updates to our provider file. You may view and update your provider information by registering on myTRICARE.com. You may file claims after 30 days of submitting your application unless notified that we require additional information. Inquiring about the status of your application within this time frame may delay processing.

Authorization as a TRICARE provider does not include a network or contractual agreement with Humana Government Business. To become a TRICARE-contracted Network Provider for the South Region, please visit www.humana-military.com to inquire about joining the network.

Indicate the name and phone number of the person to contact if additional information is needed.

NAME: RONEKIA PITTS OR PHYLLIS VERDIN PHONE: 985-868-9300

EMAIL: rpitts@slma.cc or pjverdin@slma.cc

Revised 7/21/16

Humana. Government Business

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TRICARE
NURSE / ANESTHESIOLOGIST ASSISTANT APPLICATION

NAME: _____

SOCIAL SECURITY NUMBER: _____ NPI#: _____

Do you maintain a solo practice? ☐ YES ☒ NO

IF YOU ARE SOLO INCORPORATED, PLEASE GIVE EIN NUMBER: _____

Are you employed by the U.S. Government? ☐ YES ☐ NO

OFFICE LOCATION (Street Address):	BILLING ADDRESS (If different):
1990 INDUSTRIAL BOULEVARD	1990 INDUSTRIAL BOULEVARD
HOUMA, LA 70363	HOUMA, LA 70363
Office Tele. No: (985) 868 - 9300 ext. _____	Billing Tele. No: (985) 868 - 9300 ext. _____

I will be signing my own claim forms: ☐ YES ☒ NO

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TRICARE NURSE APPLICATION

Please provider either your Registered Nurse or your Licensed Practical Nurse license number.

RN or LPN License Number: _____

Original License Date: ___/___/___ Current License Dates: From ___/___/___ To ___/___/___

In order to become TRICARE certified as any of the following Advanced Practice Nurses, you must also be licensed as a Registered Nurse.

NURSE-MIDWIFE LICENSE AND CERTIFICATION INFORMATION:

License Number: _____ Certification Number: _____

Original License Date: ___/___/___ Current License Dates: From ___/___/___ To ___/___/___

NURSE PRACTITIONER LICENSE INFORMATION:

License Number: _____ Certification Number: _____

Original License Date: ___/___/___ Current License Dates: From ___/___/___ To ___/___/___

NURSE ANESTHETISTS:

Provide the license and/or certification provided to you by either the Council on Certification of Nurse Anesthetists or by the Council on Recertification of Nurse Anesthetists.

License Number: _____ Certification Number: _____

Original License Date: ___/___/___ Current License Dates: From ___/___/___ To ___/___/___

Name of Preceptor(s) (Supervising Physician) for practice:

_____

I understand that continued privileges are contingent on continued certification by the Council on Certification on Nurse Anesthetists.

_____ _____

Signature Date

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PSYCHIATRIC NURSE SPECIALIST

☐ I am a licensed registered nurse and I have at least a master's degree in nursing with a specialization in psychiatric and mental health nursing.

NAME OF SCHOOL: _____

DEGREE: _____

DATE GRADUATED: ___/___/___

☐ I have had at least two (2) years of post-master's degree practice in the field of psychiatric and mental health nursing including an average of eight (8) hours of direct patient contact per week.

Date experience requirement was met: ___/___/_____

OR

☐ I am certified by the American Nurses Association through the American Nurses Credentialing Center (ANCC), the professional body that meets the requirement for a CPNS to be listed in a TRICARE-recognized, professionally sanctioned listing of clinical specialists in psychiatric mental health nursing.

The following ANCC certifications meet this requirement:

- Adult or Psychiatric and Mental Health Clinical Nurse Specialist (CNS)
- Child/Adolescent Psychiatric and Mental Health Clinical Nurse Specialist (CNS)
- Adult Psychiatric Mental Health Nurse Practitioner (NP)
- Family Psychiatric Mental Health Nurse Practitioner (NP)

ANESTHESIOLOGIST ASSISTANTS

Anesthesiologist Assistants must have a Master's level of Anesthesiologist Degree from an educational program accredited by the Commission on Accreditation of Allied Health Education Programs.

1. Name of Preceptor(s) (Supervising Physician) for practice:

_____

2. Highest degree level: _____

   Identify Institution: _____

PROVIDER'S NOTARIZED SIGNATURE AUTHORIZATION

STATE OF LOUISIANA COUNTY OF TERREBONNE

Know all persons by these presents:

That I, _____ have made, constituted and appointed and by these

presents do make, constitute and appoint (SEE ATTACHED LIST) (Please attach a list of any other authorized representatives) my true and lawful attorney-in-fact for me and in my name, place and stead to sign my name on claims, for payment for services provided by me submitted to Defense Health Agency (DHA). My signature by my said attorney-in-fact includes my agreement to abide by the TRICARE payment system concept and the remainder of the certification appearing on all TRICARE claim forms. I hereby ratify and confirm all that my said attorney-in-fact shall lawfully do or cause to be done by virtue of the power granted herein.

In witness whereof I have hereunto set my hand this _____ day of _____, 20____.

_____
SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, 20_____

_____
NOTARY PUBLIC IN AND FOR

COUNTY OF TERREBONNE STATE OF LOUISIANA

(SEAL) MY COMMISSION EXPIRES ____/____/____

Per Defense Health Agency (DHA) guidelines, we may accept, in lieu of a provider's actual signature on a TRICARE claim form, a facsimile signature or signature of a representative if the FI has on file a notarized authorization from the provider for use of a facsimile signature or a notarized authorization of power of attorney for another person to sign on his or her behalf.

The authorized representative may sign using the provider's name followed by the representative's initials or using the representative's own signature followed by "POA" (Power of Attorney), or similar indication of the type of authorization granted by the provider.

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PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

STATE OF LOUISIANA _____ COUNTY OF TERREBONNE _____

_____ being first duly sworn, deposes and says:
I hereby authorize the Contractor for TRICARE to accept my facsimile or stamp signature shown below:

_____

(Facsimile, stamp or computer-generated signature as it will appear on the claim form, type or print for electronic claims)

as my true signature for all purposes under TRICARE in the same manner as if it were my actual signature, including my agreeing to abide by the TRICARE payment system concept and the remainder of the certification normally signed by the source of care as it appears on all TRICARE claim forms.

_____

(Provider Signature)

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, 20____.

_____
NOTARY PUBLIC IN AND FOR

COUNTY OF TERREBONNE _____ STATE OF LOUISIANA _____

(SEAL)

MY COMMISSION EXPIRES _____/_____/_____

Per Defense Health Agency (DHA) guidelines, we may accept in lieu of a provider's actual signature on a TRICARE claim form, a facsimile signature. The facsimile signature may be produced by a signature stamp or a block letter stamp, or it may be computer-generated, if the claim is computer-generated.

PRACTITIONER AUTHORIZATION FOR REASSIGNMENT OF BENEFITS TO CLINIC

TRICARE
PGBA, LLC

It is agreed that SOUTH LOUISIANA MEDICAL ASSOCIATES
(Name of Clinic, Group or Professional Association)

will bill for and receive any charges or fees for the services of

_____
(Name of Practitioner)

1990 INDUSTRIAL BOULEVARD
(Office Address)

HOUMA, LA 70363

_____

_____ _____
Signature: Authorized Individual for Clinic Signature of Practitioner

72-0839724 _____
Employer Identification Number Social Security Number

_____ _____
NPI # for Employer Identification Number NPI # for Social Security Number

_____ _____
Date Date

Date Individual joined group practice: ___/___/_____

Please return to the address indicated at the top of this form.

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Toll-Free: 1-800-403-3950
www.myTRICARE.com by PGBA

EFT ENROLLMENT

Dear Provider:

Thank you for your interest in Electronic Funds Transfer (EFT) with PGBA, LLC. Please take a moment to review the enrollment guidelines (Appendix A). Once you have reviewed the guidelines, please complete the enclosed enrollment form (Pages 2a & 3a) with all required information, along with the Terms and Conditions located on page 4a.

In addition to EFT, PGBA, LLC. also offers Electronic Remittance Advice (ERA) which requires a separate enrollment form. If you choose both transactions, you will need to contact your 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.

To help expedite the process, you may enroll online at www.myTRICARE.com. In order to enroll online, you must have a myTRICARE secure account. If you already have a myTRICARE secure account, please first log in, if you have not done so already. If you are not a registered myTRICARE secure account holder, please go to www.myTRICARE.com and register.

If you do not wish to enroll online, please fax your completed forms to:

PGBA, LLC
TRICARE Electronic Data Interchange
FAX: 803-462-3995

Please retain a copy of the completed enrollment form for your records.

Online instructions for checking the status of EFT enrollment can be found at www.myTRICARE.com

If you do not choose to receive an 835 file or paper remittance, you have the option of viewing your remittance online at www.myTRICARE.com. For assistance with signing up to view remits online, contact myTRICARE support at 1-866-698-7422.

Please note, if you are not a TRICARE authorized provider, or an incomplete form is submitted, the enrollment form will be returned to the provider with a letter stating the reason for return

Please allow 4 weeks for the enrollment process which includes pre-note verification. If after 4 weeks you do not start receiving EFT payments, contact South Region Customer Service at 1-800-403-3950.

Once enrolled, EFT payments that have not been received after 4 business days of receipt of the corresponding ERA, online, or paper remittance can be researched by calling South Region Customer Service.

We are committed to making your transition to EFT as smooth as possible. If you have any questions regarding the information contained in this package, please contact the Provider Data Management Department by fax to 1-803-462-3995, or call the South Region Customer Service at 1-800-403-3950.

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EFT ENROLLMENT FORM

Provider Information					
Provider Name					
Provider Address					
Street					
City		State		ZIP Code/ Postal Code	
Provider Identifiers Information					
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)					
National Provider Identifier (NPI)					

☐ **NOTE:** Checking this box indicates listing **all** locations for payment with a different physical address that are to be transmitted to the Financial Institution Transit/Routing and Account number listed above. Otherwise, if only **specific** locations are to be included, list them below. **Attach additional sheets if necessary**.

TRICARE Provider Number (with suffix)	National Provider Identifier (NPI)	Business Name and Address

TRICARE South Region
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Provider Contact Information					
Provider Contact Name					
Telephone Number					
Email Address					
Fax Number					
Financial Institution Information					
Financial Institution Name					
Financial Institution Address					
City		State		ZIP Code/ Postal Code	
Financial Institution Routing Number					
Type of Account at Financial Institution (check one)	☐ Savings	☐ Checking			
Provider's Account Number with Financial Institution					
Account Number Linkage to Provider Identifier (Must match ERA Preference)					
Provider Tax Identification Number (TIN) **or** National Provider Number (NPI)					
Reason for Submission	☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment				
Authorized Signature					
Signature of Person Submitting Enrollment					
Printed Title of Person Submitting Enrollment					
Submission Date		Requested EFT Start/Change/Cancel Date			

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TERMS AND CONDITIONS FOR ELECTRONIC FUNDS TRANSFER

By Signing below your company agrees to accept payment by PGBA, LLC (PGBA) through electronic funds transfer (EFT). Additionally, you acknowledge and agree that all payments shall be made in accordance with the information that you supply on the Electronic Funds Transfer Authorization Form and that PGBA shall be entitled to rely exclusively upon such information. This agreement applies to and amends all existing agreements with PGBA by incorporating the following terms and conditions for electronic payment.

PGBA will initiate payment to you based on the following:

1. PBGA will transfer funds electronically to the financial institution and account number you register on the attached EFT/ERA Enrollment Form.

2. PGBA will make payments in accordance with and be governed by the National Automated Clearinghouse Association's Corporation Trade Payment Rules. Our process is governed by and in accordance with the laws, other than choice of law provision of any particular contract, of South Carolina, including Article 4A of the Uniform Commercial Code as enacted by South Carolina and amended from time to time.

3. The information you provide on the EFT/ERA Enrollment Form is very important. PGBA shall not be liable for any loss which may arise solely by reason of error, mistake, or fraud regarding this information. You understand that you must communicate any change in this information to PGBA. This communication must be in the form of a new EFT ERA Enrollment Form faxed to this number:

PGBA, LLC EFT
Fax: 1 803-462-3995

4. Payment is initiated within the normal terms of our agreement with you and/or applicable TRICARE procedures. Our EFT terms and conditions neither enlarge nor diminish the parties' respective rights and obligations within any applicable agreement. The payment due date is not affected. We will consider payment made when your financial institution has received or has control of the payment transaction. This will generally occur within three (3) calendar days following initiation by PGBA. If payment is initiated on a non-banking day at PGBA's originating bank, the funds transfer will occur the following banking day. In all cases, "Banking Day" is defined as the day on which both trading partners' banks are available to transmit and receive these fund transfers.

5. With respect to the EFT reimbursement process, PGBA is responsible up to the point where your financial institution receives or has control of the transaction. Any loss of data at that point will be borne by you unless the loss is due solely to the negligence of PGBA or its originating bank.

You hereby represent that you are authorized to enter into this agreement, disburse funds, sign checks, and modify account information for the provider locations listed below.

NAME: _____ SIGNATURE: _____
(Please Print)

TITLE: _____ DATE: ___/___/___

APPENDIX A
TRICARE SOUTH EFT ENROLLMENT
Form Completion Guidelines

Instructions for completing the EFT Enrollment form

- Please type or print legibly.
- Use only black or blue ink to complete paper form.
- Online form can be accessed at www.myTRICARE.com
- Please allow 4 weeks for enrollment process. If after 4 weeks you do not start receiving EFT payments, you may contact PDM Support at 1-800-403-3950 or go to www.myTRICARE.com for other contact information.

Provider Information

- **Provider Name** - Complete legal name of institution, corporate entity, practice or individual provider.
- **Provider Address**- associated with the institution, corporate entity, practice or individual provider.
- **Street** - The number and street name where a person or organization can be found.
- **City-** City associated with provider address field.
- **State/Province** - ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.
- **ZIP Code/Postal Code** - System of postal zone codes (ZIP stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery) and exploit electronic reading and sorting capabilities.

Provider Identifiers

- **Provider Federal Tax Identification Number (TIN)** - A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.
- **National Provider Identifier (NPI)** - A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Provider Contact Information

- **Provider Contact Name** - Name of a contact in provider office for handling EFT issues.
- **Telephone Number** -Associated with contact person.
- **Email Address** - An electronic mail address at which the health plan might contact the provider.
- **Fax Number** - A number at which the provider can be sent facsimiles.

Financial Institution Information

- **Financial Institution Name** - Official name of the provider's financial institution.
- **Financial Institution Routing Number -** A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited.
- **Type of Account at Financial Institution**: - The type of account the provider will use to receive EFT payments. e.g., Checking, Savings.
- **Provider Account Number with Financial Institution** - Provider's account number at the financial institution to which EFT payments are to be deposited.
- **Account Number Linkage to Provider Identifier**: Provider preference for grouping (bulking) claim payments- must match preference for V5010 X12 835 remittance advice

  Must fill out one of the two options below:
- **Providers Tax Identification Number (TIN)** - as described in "Provider Identifiers".
- **National Provider Identifier (NPI)** - as described in "Provider Identifiers".

Reason for Submission - Must select one from below

- **New Enrollment**- indicating new enrollment.
- **Change Enrollment** - write a note stating the needed change and the requested ERA effective date of the change.
- **Cancel Enrollment** - provide requested ERA effective date of the cancellation.

Authorized Signature - The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment may be used with electronic and paper-based manual enrollment.

- **Signature of Person Submitting Enrollment** - A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity.
- **Printed Name of Person Submitting Enrollment** - The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment.
- **Printed Title of Person Submitting Enrollment** - The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment.
- **Submission Date** - The date on which the enrollment is submitted.
- **Requested EFT Start/Change/Cancel Date** - The date on which the requested action is to begin.

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Provider Data Management
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Fax 803-462-3986

ERA ENROLLMENT

Dear Provider:

Thank you for your interest in Electronic Remittance Advice (ERA) with PGBA, LLC. Please take a moment to review the enrollment guidelines (Appendix B). Once you have reviewed the guidelines, please complete the enclosed enrollment form (Pages 2b & 3b) with all required information.

In addition to ERA, PGBA, LLC also offers Electronic Funds Transfer (EFT), which requires a separate enrollment form. If you choose both transactions, you will need to contact your 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.

To help expedite the process, you may enroll online at www.myTRICARE.com. In order to enroll online, you must have a myTRICARE secure account. If you already have a myTRICARE secure account, please first log in, if you have not done so already. If you are not a registered myTRICARE secure account holder, please go to www.myTRICARE.com and register.

If you do not wish to enroll online, please fax or mail your completed forms to:

FAX: 803-264-9864
PGBA, LLC
TRICARE Electronic Data Interchange
PO BOX 17150
Augusta, GA 30903

Please retain a copy of the completed enrollment form for your records.

Online instructions for checking the status of ERA enrollment can be found at www.myTRICARE.com.

Please note, if you are not a TRICARE authorized provider, or an incomplete form is submitted, the enrollment form will be returned to the provider with a letter stating the reason for return.

Please allow 4 weeks for the enrollment process to be completed. If after 4 weeks you do not start receiving ERA files, you may contact the EDI Help Desk at 1-800-325-5920, Option #2 or by Email at EDI.TRICARE@PGBA.com.

Once enrolled, ERA files that have not been received after 4 business days of receipt of the corresponding EFT file or check payment can be researched by calling or Emailing the EDI Help Desk.

We are committed to making your transition to ERA as smooth as possible. Arrangements can be made for you to receive a paper copy of your remit in conjunction with an 835 transaction file for up to 31 days by contacting the EDI Help Desk.

If you have any questions regarding the information contained in this package, please contact our EDI Help Desk at 1-800-325-5920, Option #2 or by Email to EDI.TRICARE@PGBA.com.

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ERA ENROLLMENT FORM

PROVIDER INFORMATION					
Provider Name					
PROVIDER ADDRESS					
Street					
City		State		ZIP Code/ Postal Code	
PROVIDER IDENTIFIERS INFORMATION					
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN					
National Provider Identifier (NPI)					
Other identifier(s)	Trading Partner ID		7GW _ _ _ _ _ _ _		

☐ **NOTE:** Checking this box indicates enrolling **all** locations for this provider's TIN/EIN that are active in our provider files and will no longer receive a paper remit. Otherwise, if only **specific** locations are to be included, list them below. **Attach additional sheets if necessary**.

TRICARE Provider Number (with suffix)	National Provider Identifier (NPI)	Business Name and Address

PROVIDER CONTACT INFORMATION	
Provider Contact Name	
Telephone Number	

Email Address			
Fax Number			
ELECTRONIC REMITTANCE ADVICE INFORMATION (See instructions)			
Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier)		*Provider preference for grouping (bulking) claim payment advice – must match preference for EFT payment* **Select TIN or NPI and enter below:**	
Provider Tax Identification Number (TIN) **or** National Provider Number (NPI)			
Method of Retrieval			
ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION			
Clearinghouse Name			
Telephone Number			
Email Address			
SUBMISSION INFORMATION			
Reason for Submission		☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment	
Authorized Signature			
Written Signature of Person Submitting Enrollment			
Printed Title of Person Submitting Enrollment			
Submission Date		Requested ERA Effective Date	

APPENDIX B
TRICARE SOUTH ERA ENROLLMENT
Form Completion Guidelines

Instructions for completing the ERA Enrollment form

• Please type or print legibly.
• Use only black or blue ink to complete paper form.
• Online form can be accessed at www.myTRICARE.com

Provider Information

• **Provider Name** - Complete legal name of institution, corporate entity, practice or individual provider.
• **Provider Address-** Associated with institution, corporate entity, practice, or individual provider.
• **Street** - The number and street name where a person or organization can be found.
• **City-** City associated with provider address field.
• **State/Province** - ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.
• **ZIP Code/Postal Code** - System of postal zone codes (ZIP stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery) and exploit electronic reading and sorting capabilities.

Provider Identifiers

• **Provider Federal Tax Identification Number (TIN)** - A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.
• **National Provider Identifier (NPI)** - A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Other Identifiers

• **Assigning Authority** - Organization that issues and assigns the additional identifier requested on the form.
• **Trading Partner ID** - The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor.

Provider Contact Information

- **Provider Contact Name** - Name of a contact in provider office for handling EFT issues.
- **Telephone Number** -Associated with contact person.
- **Email Address** - An electronic mail address at which the health plan might contact the provider.
- **Fax Number** -A number at which the provider can be sent facsimiles.
- **Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)** - Provider preference for grouping (bulking) claim payments - must match preference for EFT payment.

- Must fill out one of the two options below:
- **Providers Tax Identification Number (TIN)** - as explained in "Provider Identifiers".
- **National Provider Identifier (NPI)** - as explained in "Provider Identifiers"**.**

- **Method of retrieval -** Electronic remits can be retrieved in a HIPAA 835 file format directly or through a clearinghouse. Provider remits can also be viewed/downloaded from the myTricare web site if you are a member. Once set up for either method, paper remits will be stopped.

Clearinghouse Information

- **Clearinghouse Name** - Official name of the provider's clearinghouse.
- **Telephone Number** - Telephone number of contact.
- **Email Address** - An electronic mail address at which the health plan might contact the provider's clearinghouse.

Reason for Submission: Must select one from below

- **New Enrollment** - indicating new enrollment.
- **Change Enrollment** - write a note stating the needed change and the requested ERA effective date of the change.
- **Cancel Enrollment** - provide requested ERA effective date of the cancellation.

Authorized Signature - The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment may be used with electronic and paper-based manual enrollment.

- **Signature of Person Submitting Enrollment** - A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity.
- **Printed Name of Person Submitting Enrollment** - The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment.
- **Printed Title of Person Submitting Enrollment** - The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment.
- **Submission Date** - The date on which the enrollment is submitted.
- **Requested ERA Effective Date** - Date the provider wishes to begin ERA; per Phase III CORE Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0: there may be a dual delivery period depending on whether the entity has such an agreement with its trading partner.