# Electronic Remittance Advice (ERA)
# Provider Registration Request and Cancel Form

CIGNA HealthCare

**INSTRUCTIONS TO CLEARINGHOUSE:**

A. Please complete this form for a Provider requesting to register to receive an Electronic Remittance Advice (ERA) from CIGNA HealthCare, or, requesting to cancel an ERA registration (including a cancellation due to provider change in Clearinghouse).

B. **E-mail the completed form to info@inmediata.com**. (Note: Your clearinghouse will forward the registration request/change to CIGNA HealthCare.)

**Notes:**

a) Provider Records will be updated within 10 business days of receipt of this form by CIGNA HealthCare.

b) ERA's will be produced beginning the first payment cycle after the ERA effective date:
- for claims received after the ERA effective date,
- for claims received before the ERA effective date, if processed and consolidated on same check with claims received after the ERA effective date.

Note that the "ERA effective date" is the date requested, or, the current date at the time the registration request is processed by CIGNA, whichever is later. Retroactive dates are not accommodated.

c) ERA election will be effective for all practitioners registered within the same TIN.

d) If you elect to have ERAs for the same TIN distributed by Service Facility, you will need to submit the Service Facility ID number on your claims. Please check with; your clearinghouse for more details.

e) If you elect to have ERAs for the same TIN TIN distributed by Srvice Facility, you will need to sibmit the Service Facility ID number on your claims. Please check with your clearinghouse for more details.

f) Explanation of Payments (currently provided) will continue to be produced.

| **(1) ACTION REQUESTED** *(Select one)* | | **(2) EFFECTIVE DATE** | |
|---|---|---|---|
| ENROLL FOR ERA<br>(Note: Explanation of Payments currently provided will continue). | ☐ CANCEL ERA<br>(Note: For any reason, including change in Clearinghouse). | INDICATE THE ERA EFFECTIVE DATE OR CANCEL DATE REQUESTED.<br>*(Specify date –mm/dd/yyyy)*<br>(Note: Future Date only.) | |

**(3) PROVIDER INFORMATION** *(Please select those that apply.)*

| | | | | | |
|---|---|---|---|---|---|
| ☐ MEDICAL | ☐ DENTAL | ☐ BOTH | ☐ DISTRIBUTE ERA BY SERVICE FACILITY | | |
| **TIN** (TO WHICH PAYMENT WILL BE MADE). | | TIN TYPE (INDICATE SSN OR EIN): | ☐ SSN | ☐ EIN | |
| **TIN** (TAX ID) NAME ON W-9. | | | | | |

| **PLEASE COMPLETE APPLICABLE OPTIONS BELOW** | |
|---|---|
| SOLO PRACTITIONER FIRST/LAST NAME & DEGREE | |
| GROUP NAME (IF APPICABLE) | |
| ANCILLARY NAME | |
| FACILITY NAME | |

| **PLEASE MARK APPLICABLE OPTION** | |
|---|---|
| **FOR FACILITIES:** | **FOR ANCILLARIES:** |
| ☐ HOSPITAL ☐ HOSPICE ☐ SKILLED NURSING | ☐ LABORATORY ☐ DME ☒ X-RAY CENTER ☐ MENTAL HEALTH |
| ☐ OTHER: | ☐ OTHER: |

| **BILLING ADDRESS** | | | |
|---|---|---|---|
| STREET / PO BOX | | | |
| CITY | | | |
| STATE | | ZIP CODE | |
| BILLING CONTACT NAME | | FAX NO. | |
| TELEPHONE NO. | | E-MAIL ADDRESS | |

**(4) CLEARINGHOUSE INFORMATION**

| | | | |
|---|---|---|---|
| CLEARINGHOUSE ID# | **660610220** | CLEARINGHOUSE NAME: | **INMEDIATA** |
| PHONE # | **(787)783-3233** | FAX # | **1-866-597-0277** |
| E-MAIL ADDRESS & CONTACT NAME | **info@inmediata.com Sylvia González** | DATE REQUEST COMPLETED | |
| FOR CIGNA INTERNAL USE ONLY | DATE REQUEST RECEIVED: | | |