InstaMed®
Healthcare Payments Simplified

CareSource

The InstaMed Network Electronic Funds Transfer Enrollment Form

Please complete this form to enroll in both the InstaMed Provider Portal to view electronic remittances (ERA) and to enroll in Electronic Funds Transfer (EFT). Please return the completed form along with a voided check to enroll in Electronic Funds Transfer, via fax or mail to:

FAX: (877) 755-3392

MAIL: InstaMed
P.O. Box 58790
Philadelphia, PA 19102

QUESTIONS? (215) 789-3682

NOTE: By enrolling in EFT/ERA, you agree that you will NO LONGER receive a paper check or paper Explanation of Payment. These are available on the Provider Portal.

SECTION ONE – GENERAL INFORMATION

Provider Information (*all information is required unless otherwise noted*)

If you want to enroll more than one provider, please list additional names, NPIs and Tax IDs on a separate sheet and submit.

	Practice Administrator Contact Information
Provider Name	
Practice Name	Name
Address	Phone
City State Zip	Email
Practice/Provider Billing NPI *(if available)*	Fax

Practice/Provider Tax IDs

Please provide your billing Tax ID(s) for the above named provider and, if populated, practice name. Tax ID is required for account setup.

Tax ID: __________________ **Tax ID**: __________________ **Tax ID**: ________________ **Tax ID**: __________________

EIN ☐ SSN ☐ EIN ☐ SSN ☐ EIN ☐ SSN ☐ EIN ☐ SSN ☐

SECTION TWO – REMITTANCE FILE DELIVERY

Please select your options to receive Electronic Remittance Advice (*ERA*):

☐ Receive ERA through InstaMed secure Provider Portal only

☐ Receive ERA via Secure File Transfer Protocol (*SFTP*)

☐ Receive ERA via Clearinghouse
Clearinghouse Name: _______________________

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SECTION THREE – ELECTRONIC FUNDS TRANSFER

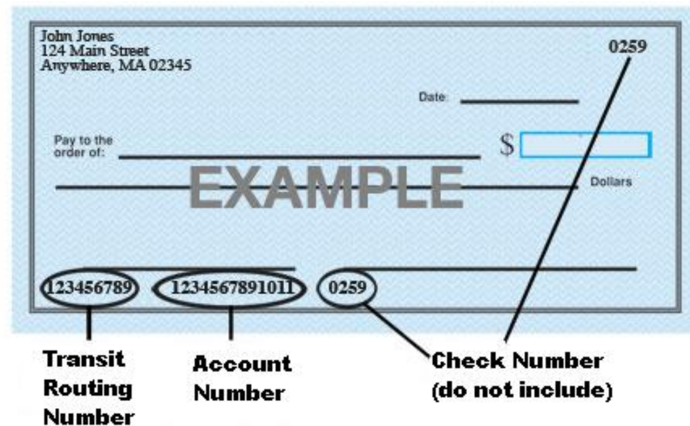
Complete the following information and attach a voided check or photocopy of a voided check. One form is required per bank account. You should begin to receive electronic reimbursement on behalf of CareSource after your successful enrollment is processed.

Settlement Information

Bank Name	Bank Address
Transit Routing Number (TRN)	City State Zip
Account Number	Account Type: ☐ Savings ☐ Checking

IMPORTANT: Please attach voided check or a photocopy of a voided check:

<attach voided check here>



Authorization

The undersigned authorizes InstaMed Communications, LLC D.B.A InstaMed to make electronic debits, payments and adjusting entries to the bank account at the depository financial institution (depository) named above for services performed under the network participation agreement between the organization identified above and InstaMed and its affiliates. Such debits, payments and entries shall be made through the regional automated clearinghouse (ACH) associations, subject to the operating rules of the National Automated Clearinghouse Association. This authorization is to remain in full force and effect until InstaMed has received written notice of its termination, allowing us reasonable opportunity to act on it, but in no event later than thirty (30) days advance notice. Revocation will not apply to transactions initiated before the effective date of such revocation. Although no fees are currently charged for this service, in the event InstaMed elects to impose fees, we will notify you in advance. If you do not terminate this authorization after such notice, you authorize InstaMed to deduct such fees from the transfers of funds owed to you under the network participation agreement to the depository specified above. InstaMed may cease providing any or all of these services upon notice to the Primary Contact named above. The undersigned certifies that the above information is true and accurate in all respects and that the undersigned has the authority to initiate the actions requested herein and will promptly notify InstaMed of any changes to the information on this form in writing. InstaMed reserves the right, in its sole discretion, to provide the information regarding the undersigned provided in this form, and the undersigned hereby consents to the provision of such information by InstaMed, to CareSource, Inc. and/or its affiliates, provided that (i) the undersigned has not requested in writing that InstaMed not disclose such information to CareSource, Inc. and/or its affiliates, and (ii) that any such disclosure is otherwise permitted under all applicable legal and regulatory requirements and healthcare and payment industry security standards related to the collection, retention and use of such information.

Authorized Signature Required

Printed Name	Title
Signature	Date

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