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CONFIDENTIAL

# INSTAMED NETWORK FUNDING AGREEMENT
## (Payer Payments)

**To register online instead of using this paper form, please visit www.instamed.com/eraeft.**

This **NETWORK FUNDING AGREEMENT** (the "Agreement") shall become effective upon execution by "Customer". The services that Customer is enrolling for pursuant to this Agreement shall be subject to the InstaMed Terms and Conditions located at http://www.instamed.com/im-online/terms_and_conditions.html (the "T&Cs"). Customer acknowledges that it has reviewed, and hereby agrees, by its signature below, to be bound by, the T&Cs.

NOTE: By registering for Payer Payments (see Section Four below), you agree that you will NO LONGER receive a paper check or paper explanation of payment (EOP) from the payers listed on the Provider Portal, as it may be updated from time to time.

Providers registering for Payer Payments will automatically receive Integrated ERA/EFT® from all available payers on the InstaMed Network. For a list of available payers, visit http://info.instamed.com/payer-payments-payer-list. To opt out of Integrated ERA/EFT® from one or more of the available payers, please contact InstaMed at (866) 945-7990 or connect@instamed.com.

**Please complete the form below, sign and send to InstaMed: (*For security purposes, please do not return this form via email.*)**

- **Fax: (877) 755-3392**
  **or**
- **Mail: P.O Box 58790 Philadelphia, PA 19102**

**If you have any questions, please contact InstaMed at (866) 945-7990.**

## SECTION ONE – GENERAL INFORMATION

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

| | |
|---|---|
| Tax ID | **Practice Administrator Contact Information** |
| Provider Name (*an individual*) | Name |
| Practice Name (*a business entity*) | Phone |
| Address | Email |
| City State Zip | Fax |
| Practice Management System | |

## SECTION TWO – NPI

### NPIs

**Please give your Billing Provider NPI(s) for the Provider Name above and, if populated, Practice Name. If your Practice uses Service Provider NPI(s) for claims billing, please list them also. If your Practice does not use Service Provider NPI(s) for claims billing, you do not need to list them. In order to avoid misdirected payments, only list NPI(s) that should have ALL of their remittances and payments routed to you. Do not include NPI(s) that also do business under other healthcare providers.**

Billing Provider NPI (*Practice NPI*): _____ Billing Provider NPI (*Practice NPI*): _____

Service Provider NPI: _____ Service Provider NPI: _____

## SECTION THREE – REMITTANCE DELIVERY

**You will automatically receive ERAs through the InstaMed secure Provider Portal. Please indicate below if you want to receive ERA via Secure File Transfer Protocol (SFTP) and/or your clearinghouse in addition.**

- ☒ Receive ERA via InstaMed secure Provider Portal
- ☐ Receive ERA via SFTP (*Optional*)
- ☐ Receive ERA via Clearinghouse (*Optional*)
  Clearinghouse Name: _____

For a list of supported clearinghouses for ERA, visit: www.instamed.com/eraclearinghouses.

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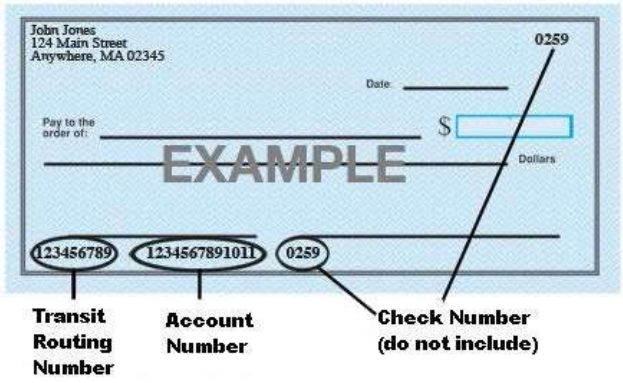
## SECTION FOUR – ELECTRONIC FUNDS TRANSFER

**Please complete the form below and attach a voided check or photocopy of a voided check. One form is required per bank account.**

### Bank Account Information

| | |
|---|---|
| Tax ID (*same as page 1*) | Bank Street Address |
| Bank Name | City State Zip |
| Transit Routing Number (TRN) (*see graphic below*) | Account Number (*see graphic below*) |

ATTACH VOIDED CHECK HERE OR ON SEPARATE PAGE OR ATTACH A PHOTOCOPY OR BANK LETTER ON A SEPARATE PAGE




## SECTION FIVE – AUTHORIZATION

By signing below, you confirm that the information that you have provided in this Agreement is true, complete and correct and you also hereby agree to the T&Cs set forth at http://www.instamed.com/im-online/terms_and_conditions.html, which is integral to, and forms a part of, this Agreement.

### Authorized Signature

Name of Customer: _____ Date: _____

Signature: _____

Print Name: _____

Print Title: _____

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Internal Use Only: Network Build Initials: _____