INSTAMED ERA ROUTING FORM

CONFIDENTIAL

This **ERA ROUTING FORM** (the "Form") shall become effective upon execution by "Customer". The services that Customer is enrolling for pursuant to this Form 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.

Please complete the Form below, sign and send to InstaMed:

- **Email: support@instamed.com**
  or
- **Fax: (866) 682-1110**

If you have any questions, please call InstaMed at (866) INSTAMED or (866) 467-8263, or email at support@instamed.com.

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 – 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.

SECTION THREE – AUTHORIZATION

By signing below, you confirm that the information that you have provided in this Form 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 Form.

Authorized Signature

Name of Customer: _____ Date: _____

Signature: _____

Print Name: _____

Print Title: _____

Internal only	*Case Number:*	*Account Number:*	*Sent By:*