InstaMed®
Healthcare Payments Simplified

INSTAMED ORDER FORM - PAYER PAYMENTS

Get paid faster and easier with ERA/EFT.

Complete Online
register.instamed.com/eraeft

Instructions

1. Review and complete entire form
2. Sign signature field(s)
3. Send through secure fax: (877) 755-3392 **or mail:** PO Box 58790, Philadelphia, PA 19102

Incomplete forms will not be accepted

DESCRIPTION

SOLUTION DESCRIPTION

By registering for Payer Payments, you will receive payments from the payers listed at the following URL (http://info.instamed.com/payer-payments-payer-list) by electronic funds transfer (EFT) and claims information by electronic remittance advice (ERA). After you register for Payer Payments, you will no longer receive a paper check or paper explanation of payment (EOP) from the payers listed at the URL set forth in the prior sentence, which URL InstaMed may update from time to time to add or remove payers. To opt out of Payer Payments from one or more of the available payers, please contact InstaMed at (866) 945-7990 or connect@instamed.com.

CUSTOMER INFORMATION

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Primary Contact

Name (First/Last) _____

Title _____

Phone _____

Email _____

Billing Address

Customer Legal Name _____

Customer DBA Name (If different) _____

Street Line 1 _____

Street Line 2 _____

City _____ State _____ Zip _____

Number of Providers _____ Tax ID _____

Patient Accounting System _____ Version _____

Remittance Delivery

You will automatically receive ERAs through the InstaMed secure Provider Portal. To receive ERAs through your clearinghouse, please list your clearinghouse below. For a list of supported clearinghouses for ERA, visit: www.instamed.com/eraclearinghouses.

Clearinghouse: _____ ☐ Check this box to receive ERAs via SFTP (**Secure File Transfer Protocol**)

NPIs

Please give your Billing Provider NPI(s) and, if you use 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: _____ Billing Provider NPI: _____

Billing Provider NPI: _____ Billing Provider NPI: _____

Internal Initials: _____

BANK ACCOUNT INFORMATION

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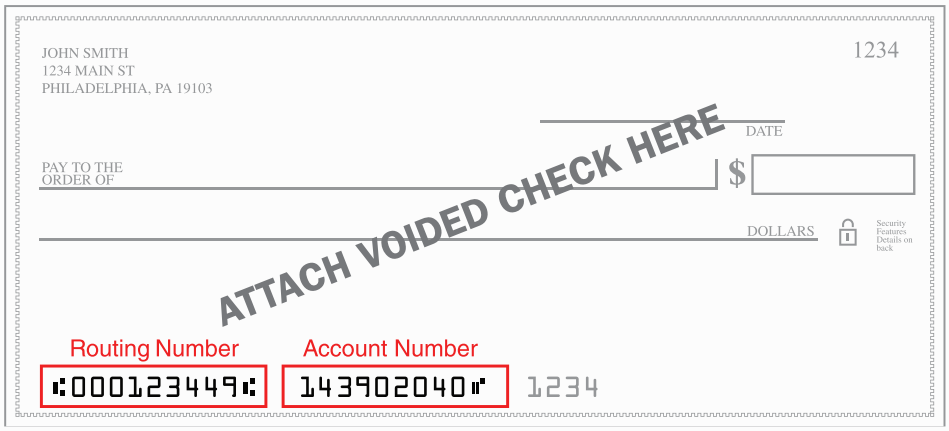
Bank account information is required for payer payment deposits. A voided check or bank letter is required.

Bank Name _____ Routing Number _____ Account Number _____



AUTHORIZATION

AGREED AND ACCEPTED

By signing below, you agree to the terms of this Order Form and you confirm that the other information that you have provided in the Order Form is true and correct. You also agree to the Terms and Conditions set forth at www.instamed.com/im-online/terms_and_conditions.html or separately agreed to in writing by you and InstaMed, which are integral to, and form a part of, this Order Form. The parties consent and agree that this Order Form may be electronically signed. The parties agree the electronic signatures appearing on this Order Form are the same as hand-written signatures for purposes of validity, enforceability and admissibility.

Customer Legal Name _____

Tax ID (same as page 1) _____

Signature _____ Date _____

Print Name _____

Title _____

GA-P-0218

DCH Approved: June 6, 2017

Internal Initials: _____