

**Office of Management and Enterprise Services  
Employees Group Insurance Department  
(HealthChoice, Department of Rehabilitation Services, and Department of Corrections)  
Non-Network Provider Electronic Remittance Advice (ERA) Enrollment Form**

**PROVIDER INFORMATION**

Provider Name	
Provider Address:	
Street	
City	
State/Province	
ZIP Code/Postal Code	

**PROVIDER IDENTIFIERS INFORMATION**

Provider Identifiers:	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	
National Provider Identifier (NPI)	

**ELECTRONIC REMITTANCE ADVICE INFORMATION**

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier):	
Provider Tax Identification Number (TIN)	

**ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION**

Clearinghouse Name	
Clearinghouse Contact Name	
Telephone Number	

**SUBMISSION INFORMATION**

Reason for Submission:	<i>(select one)</i>
New Enrollment	<input type="checkbox"/>
Change Enrollment	<input type="checkbox"/>
Cancel Enrollment	<input type="checkbox"/>

**AUTHORIZED SIGNATURE**

*By signing below you acknowledge you are the provider or an authorized representative for the provider named on this form. You further acknowledge the information above is correct and you are providing authorization to begin receiving ERA transactions.*

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Written Signature of Person Submitting Enrollment

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Printed Name of Person Submitting Enrollment

    /    /    (CCYY / MM / DD)

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Submission Date

## Instructions for Completing the Non-Network ERA Enrollment Form

**Return the completed form to:**

Hewlett Packard Administrative Services, LLC  
 P.O. Box 24110  
 Oklahoma City, OK 73124  
 Or email to: [hpera.mailbox@hpe.com](mailto:hpera.mailbox@hpe.com)

To ensure the security of your information when submitting this form via email, please submit your form and any attachments in an encrypted WinZip file, then submit the password for the WinZip file in a separate email.

If you have any questions, please contact Hewlett Packard Administrative Services, LLC at 1-405-416-1800 or toll free 1-800-782-5218. TDD users call 1-405-416-1525 or toll free 1-800-941-2160.

Information for how to obtain the status of your ERA enrollment can be found at:

<https://www.okhcp-eds.com/HCP/Default.aspx?alias=www.okhcp-eds.com/hcp/provider>

**If enrolled in EFT and Electronic Remittance Advice (ERA), you must contact your financial institution to arrange for the delivery of the CORE-required minimum CCD+ data elements needed for reassociation of the payment and the ERA.**

Form Field	Form Field Description	Additional Information/Instructions
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider.	Required
Provider Address: Street	The number and street name where a person or organization can be found.	Required
Provider Address: City	City associated with the provider address field.	Required
Provider Address: State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.	Required
Provider Address: ZIP Code/Postal Code	System of postal-zone codes (zip stands for “zone improvement plan”) introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.	Required
Provider Identifiers: Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.	Required; Numeric; 9-digits
Provider Identifiers: National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in	Required when the provider has been enumerated with an NPI Numeric; 10-digits

	lieu of legacy provider identifiers in the HIPAA standards transactions.	
Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier): Provider Tax Identification Number (TIN)	Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFT payment.	Required; Numeric; 9-digits
Clearinghouse Name	Official Name of the provider’s clearinghouse	Required; i.e., Change Healthcare This should be the clearinghouse who is currently handling your electronic claims for HealthChoice, Oklahoma Department of Corrections and/or Oklahoma Department of Rehabilitation Services Any request for routing of ERAs to another destination will require additional setup and testing.
Clearinghouse Contact Name	Name of a contact in clearinghouse office for handling ERA issues	Required
Telephone Number	Telephone number of contact	Required
Reason for Submission		Required Select either New Enrollment, Change Enrollment or Cancel Enrollment below
New Enrollment		Check here if this is a new enrollment
Change Enrollment		Check here if this is a change to enrollment information
Cancel Enrollment		Check here if this is a request to cancel enrollment
Authorized Signature	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment.	
Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity.	Required; Sign name here
Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment.	Required; Print name here
Submission Date	The date on which the enrollment is submitted.	Required; Enter date