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# 835 HEALTH CARE ELECTRONIC REMITTANCE ADVICE (ERA) NEW REQUEST FORM

## Section A - Provider Information

PLEASE INDICATE YOUR CLASSIFICATION (CHECK ALL THAT APPLY)

- INDIVIDUAL PROVIDER       GROUP/PRACTICE       FACILITY       BOTH GROUP & FACILITY

PROVIDER/GROUP NAME

PROVIDER TAX ID

MULTIPLE TAX IDs (SEE ATTACHMENT 1)

PROVIDER CONTACT NAME

PROVIDER BILLING ADDRESS

CITY

STATE

ZIP

PROVIDER CONTACT PHONE NUMBER

PROVIDER CONTACT EMAIL

## Section B - Vendor Information

VENDOR NAME

VENDOR CONTACT NAME

VENDOR CONTACT PHONE NUMBER

By checking here, Provider authorizes Health New England, Inc. to transmit Provider's 835 files to Vendor.

## Section C - Authorization Signature

Provider, \_\_\_\_\_, hereby appoints  
*Provider Name/Provider Representative Name (please print)*

\_\_\_\_\_ to act as the authorized agent for  
*Vendor (please print)*

the purpose of retrieving the 835 electronically from Health New England, Inc.

PROVIDER/PROVIDER REPRESENTATIVE NAME (PRINTED)

DATE

PROVIDER/PROVIDER REPRESENTATIVE SIGNATURE

