IdealCare SENDERO HEALTH PLANS

Electronic Remittance Advice (ERA) Form

Authorization	
Provider Name:	
Tax ID:	Group NPI Number:
Contact Name:	Contact Phone:
Contact E-mail:	Contact Fax:
I (we) elect to receive ERA835 EDI/EOP. All options are paperless. Select One. ☐ ERA835 EDI via Clearinghouse	Clearinghouses: ☐ Relay ☐ Change Healthcare

This authorization is to remain in effect until Sendero Health Plans has received written notification from me of its termination in such time, and in such manner as to afford Sendero Health Plans and Financial Institution a reasonable opportunity to act on it.

☐ **I agree to applicable Terms and Conditions.**

The undersigned person represents and warrants that he/she is authorized to execute this form on behalf of the Provider.

Authorized Signature:	Date:
Printed Name:	Title:

Print Form

Fax to 713.295.7055 – Attention: Provider Database Support

Revised 8/01/17