Electronic Remittance Advice (ERA)

1. **Provider Information**
   Provider Name:

2. **Provider Identifiers**
   Provider Federal Tax Identification (TIN) or Employer Identification Number (EID):
   Provider NPI:
   KY Medicaid Provider ID (Assigned Authority):

3. **KY Medicaid Trading Partner ID**
   Enter the Trading Partner ID to be used to retrieve ERA (10 digits beginning with 99):

4. **Provider Contact Information**
   Provider Contact Name:
   Title:
   Telephone Number (including extension): Ext:
   Email Address:
   Fax Number:

5. **Clearinghouse Information**
   Clearinghouse Name:
   Clearinghouse Contact Name:
   Telephone Number:
   Email Address:

6. **Reason for Submission**
   Select the option below for the applicable reason for 835/277U ERA Enrollment submission:

   ◯ New Enrollment ◯ Change Enrollment ◯ Cancel Enrollment

7. **Submission Date:** 01/09/2023

8. **Effective ERA Date:**

I understand that in the event that a different trading partner is selected to retrieve the 835 ERA, I must notify the EDI Helpdesk immediately by completing a new 835 ERA enrollment form. I will not hold the EDI Helpdesk liable for incorrect information submitted on the 835 ERA enrollment form.

If 'Cancel Enrollment' is indicated under 'Reason for Submission', I, the undersigned, hereby cancel the authorization for the Department for Medicaid Services to generate an 835 for the next payment cycle.

9. **Title:**
10. **Electronic Signature:**

Submit ERA Form

NOTE: SELECTING THIS BUTTON SUBMITS THE ELECTRONIC REMITTANCE ADVICE FORM