

Electronic Remittance Advice Request (ERA)

LOUISIANA, MISSOURI, NEW MEXICO, OKLAHOMA

Submitter Information

Submitter Number of Provider/Group: _____

Submitter Number *picking up the remittance advice*: _____

Effective Date: _____

Provider Name: (Hospital, Clinic, or P.A. Group): _____

Medicare Provider Number: (Clinic number): _____

Address: _____

City/State/Zip: _____

Contact Person's Name: _____

Telephone Number: _____

Provider Information

Provider Name

Medicare Provider Number

Attach additional sheets if necessary

Indicate the Line of Business For ANSI 835 Transaction

Medicare Part B Professional _____

Signature and Title (Provider and/or CEO, CFO, COO of Clinic)

Date

RETURN ADDRESS:
Medicare Services
Attn: EDI - 4BCS
P.O. Box 2181
Little Rock, AR 72203-2181

