Electronic Remittance Advice Request

Providers who receive payment of claims by Centene Health Plans can request electronic remittance advices for their respective health plan. Please list the health plan name on the line below for the health plan you currently bill claims to for payment.

By signing the form below you are authorizing Centene Corporation to send your electronic remittance via the following clearinghouse:

Health Plan name: _____

Health Plan Payer ID & State: _____ State _____

Payee Name: _____

Payee Phone Number: _____

IRS#: _____

NPI#: *_____

*List all that apply.

Is your practice filing claims as group? ☐ **or Individual?** ☐

Please Choose one

Address: _____

City, State and Zip code: _____

835 ☐ Yes, Please send electronic explanation of payment

Clearinghouse Name: _____

Clearinghouse ID#: _____

Sender/Receiver ID: _____

Technical Contact Name: _____

Technical Contact Phone: _____

Remit

☐ Yes, please send a paper copy of the explanation of payment

☐ No, please do not send a paper copy of the explanation of payment

If you answer YES to both the '835' and 'Remit', the paper copy will discontinue after 60 days.

Please note if you would like EFT's (Electronic Funds Transfers) set up you will need to contact PaySpan Health at: **(877) 331-7154. Visit their website at:** *www.payspanhealth.com*

Signature of Provider or Administrator: Date:

_____ _____

Contact email address:

_____ _____

FAILURE TO COMPLETE FORM WILL DELAY PROCESSING YOUR REQUEST

For internal use only:

Received date: _____ By: _____

Provider or group id: _____

Please send completed form to: ediba@centene.com or fax to 866-266-6985