OPTUM Rx®

Tracking ID #XXXXX

Electronic remittance advice enrollment form

Submission information

Reason for submission (Check the one that applies)

☐ New enrollment ☐ Change enrollment ☐ Cancel enrollment Submission date _____

Name of person submitting enrollment _____ Title _____

Provider information

Provider name _____

Doing business as name (DBA) _____

Street _____ City _____

State/province _____ ZIP code/postal code _____ Country code (optional) _____

Provider identifiers

Provider Federal Tax Identification Number (TIN) _____ or National Provider Identifier (NPI) _____

Assigning authority _____ Trading partner ID _____

Provider contact information

Provider contact name _____

Telephone number _____ extension _____

Email address _____

Retail pharmacy information (optional except for pharmacies)

Pharmacy name _____ chain number _____

NCPDP provider ID number _____

Electronic remittance advice information

Preference for aggregation of remittance data* _____

Pharmacy Federal Tax Identification No. (TIN) _____ Pharmacy National Identifier (NPI) _____

Method of retrieval (write in method)** _____

Electronic remittance advice clearinghouse information

Clearinghouse name _____

Email address _____

Electronic remittance advice vendor information

Vendor name _____

Email address _____

Electronic media/trading partner information

NCPDP, NPI, or Chain ID Number*** _____ FTP Host Address*** _____

FTP Directory*** _____ FTP Password*** _____

Electronic media contact information

First name*** _____ Last name*** _____

Title*** _____ Phone*** _____

Email address*** _____

ERA trading partner request form

Pharmacy information:

Pharmacy name*** _____ Chain code or NCPDP#*** _____

IT (FTP) contact name*** _____ IT (FTP) contact phone number*** _____

File transfer protocol (FTP) information:

FTP host address*** _____ FTP login*** _____

FTP password*** _____ FTP directory*** _____

PGP key name*** _____

Send completed forms to:

OptumRx
P.O. Box 6104
Cypress, CA 90630-6104
Fax number:800-732-7601

*Provider preference for grouping (bulking) claim payments — must match preference for v5010X12 835 remittance advice

**The method in which the provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.)

*** Indicates a required field