AUTO PAY

PROVIDER ENROLLMENT OPTIONS

Out-of-Network Providers may receive payments and remittance advice in one of several ways:

- FREE Printed, mailed checks and Explanations of Payment (EOPs). No action necessary!
- Zelis ePayments through ACH or virtual card. Visit ZelisPayments.com to learn more.

In-Network Providers may receive payments and remittance advice in one of several ways:

- FREE Printed, mailed checks and Explanations of Payment (EOPs). No action necessary!
- Consolidated ePayments from Zelis through ACH or virtual card. Visit ZelisPayments.com to learn more.
- FREE Auto Pay (Electronic Funds Transfer) with 835 remittance advice and electronic EOPs in the Provider Portal. See enrollment instructions below.

TO ENROLL IN FREE AUTO PAY	1. Complete the Enrollment Form at the Group/Tax ID level. Please note the field clarifications below. • Provider Name – Legal Group Name • Provider Address Fields – Pay To Address Information • NPI – Group NPI • Provider Contact Name & Provider Email – name and email of the person within the practice who should be contacted with questions ➢ **Attach a copy of a voided check or bank letter.** (Please note, the name of the check must match the name on the form.) ➢ Note: All fields must be completed. 2. Return enrollment form and copy of voided check or bank letter to Alliant Health Plans, Attn: Provider Relations, PO Box 1128, Dalton, GA 30722 or email to ProviderRelations@AlliantPlans.com. 3. Your Provider Relations Representative will review your submission and reach out for any additional information needed.
EXPLANATIONS OF PAYMENT	By opting to receive electronic payments, providers forfeit the receipt of printed and mailed Explanations of Payment (EOPs). Once enrolled in AutoPay, EOPs may only be accessed through the online Provider Portal. Please contact your practice administrator or email ProviderRelations@AlliantPlans.com for access instructions.
ELECTRONIC REMITTANCE OR 835 FILES	Alliant Health Plans offers 835 return files (or electronic remittance files) through Change Healthcare. The enrollment process is separate from Auto Pay enrollment as the provider must enroll directly with Change Healthcare. To enroll, please visit support.changehealthcare.com and enter the Alliant Health Plans payer ID (58234) into the search field. In the search results, select the appropriate form type (professional or facility), complete and submit the enrollment form according to the instructions on the form. Change Healthcare will notify Alliant when provider enrollment in 835 return files has been completed.

AUTO PAY

PROVIDER AUTHORIZATION AGREEMENT

Provider Name	Doing Business As (DBA)
Provider Street Address	**Provider City**
Provider State/Province	**Provider Zip Code/Postal Code**
Provider Tax Identifier (TIN) or Employer Identifier (EIN)	**National Provider Identifier (NPI)**
Provider Contact Name	**Provider Email Address**
Provider Phone Number	**Provider Fax Number**
Financial Institution Name	**Financial Institution Street Address**
Financial Institution Telephone Number	**Financial Institution City/State/Zip Code**
Financial Institution Routing Number	**Type of Account at Financial Institution**
Provider's Account Number at Financial Institution	**Provider Preference for Grouping Claim Payments**
	Check one: ☐ TIN ☐ NPI

Reason for Submission			
Check one:	☐ NEW	☐ CHANGE	☐ CANCEL

I (we) hereby authorize Alliant Health Plans to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I am (we are) responsible for the validity of the information on this form. If Alliant Health Plans erroneously deposits funds into my (our) account, I (we) authorize Alliant Health Plans to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay cycle.

I (we) agree to comply with all certification and credentialing requirements of Alliant Health Plans and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by Alliant Health Plans or its authorized affiliate(s) or subcontractor(s). I (we) will continue to maintain the confidentiality of records and other information relating to clients covered by programs offered through Alliant Health Plans in accordance with applicable state and federal laws, rules, and regulations.

Authorizing Signature _____ Date Signed _____

Printed Name _____ Title of Person Signing _____

For the convenience of having direct deposit, you must be willing to download your EOB/EOP directly from www.alliantplans.com. ***No paper copies will be mailed.***

PLEASE RETURN THIS FORM ELECTRONICALLY or MAIL TO:

Alliant Health Plans | ProviderRelations@AlliantPlans.com | PO Box 1128| Dalton, GA 30722

**** Forms must be mailed in or scanned and sent by email. Fax copies WILL NOT be accepted due to readability.***