InstaMed
Healthcare Payments Simplified

CONFIDENTIAL

INSTAMED NETWORK FUNDING AGREEMENT
(Payer Payments)

To register online instead of using this paper form, please visit www.instamed.com/eraeft.

This **NETWORK FUNDING AGREEMENT** (the "Agreement") shall become effective upon execution by "Customer". The services that Customer is enrolling for pursuant to this Agreement shall be subject to the InstaMed Terms and Conditions located at http://www.instamed.com/im-online/terms_and_conditions.html (the "T&Cs"). Customer acknowledges that it has reviewed, and hereby agrees, by its signature below, to be bound by, the T&Cs.

NOTE: By registering for Payer Payments (see Section Four below), you will receive payments from the payers listed at the following URL (http://info.instamed.com/payer-payments-payer-list) by electronic funds transfer (EFT) and claims information by electronic remittance advice (ERA). After you register for Payer Payments, you will no longer receive a paper check or paper explanation of payment (EOP) from the payers listed at the URL set forth in the prior sentence, which URL InstaMed may update from time to time to add or remove payers. To opt out of Payer Payments from one or more of the available payers, please contact InstaMed at (866) 945-7990 or connect@instamed.com.

Please complete the form below, sign and send to InstaMed: (*For security purposes, please do not return this form via email.*)

- **Fax: (877) 755-3392**
  or
- **Mail: P.O. Box 58790 Philadelphia, PA 19102**

If you have any questions, please contact InstaMed at (866) 945-7990.

SECTION ONE – GENERAL INFORMATION

Provider Information (*all information is required unless otherwise noted*)

	Practice Administrator Contact Information
Tax ID	
Provider Name (*an individual*)	Name
Practice Name (*a business entity*)	Phone
Address	Email
City State Zip	Fax
Practice Management System	

SECTION TWO – NPI

NPIs

Please give your Billing Provider NPI(s) for the Provider Name above and, if populated, Practice Name. If your Practice uses Service Provider NPI(s) for claims billing, please list them also. If your Practice does not use Service Provider NPI(s) for claims billing, you do not need to list them. In order to avoid misdirected payments, only list NPI(s) that should have ALL of their remittances and payments routed to you. Do not include NPI(s) that also do business under other healthcare providers.

Billing Provider NPI (*Practice NPI*): _____ Billing Provider NPI (*Practice NPI*): _____

Service Provider NPI: _____ Service Provider NPI: _____

SECTION THREE – REMITTANCE DELIVERY

You will automatically receive ERAs through the InstaMed secure Provider Portal. Please indicate below if you want to receive ERA via Secure File Transfer Protocol (SFTP) and/or your clearinghouse in addition.

- ☒ Receive ERA via InstaMed secure Provider Portal
- ☐ Receive ERA via SFTP (*Optional*)
- ☐ Receive ERA via Clearinghouse (*Optional*)
  Clearinghouse Name: _____

For a list of supported clearinghouses for ERA, visit: www.instamed.com/eraclearinghouses.

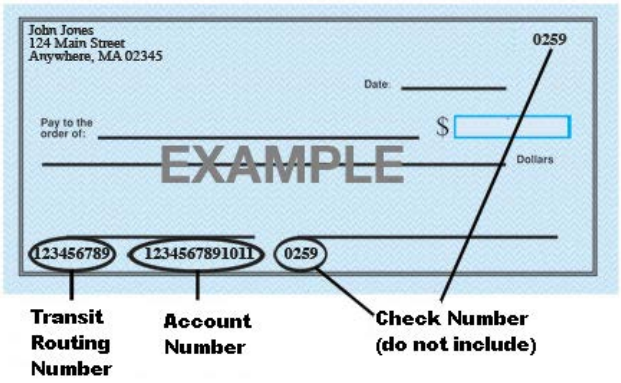
SECTION FOUR – ELECTRONIC FUNDS TRANSFER

Please complete the form below and attach a voided check or photocopy of a voided check. One form is required per bank account.

Bank Account Information

Tax ID (*same as page 1*)	Bank Street Address
Bank Name	City State Zip
Transit Routing Number (TRN) (*see graphic below*)	Account Number (*see graphic below*)

ATTACH VOIDED CHECK HERE OR ON SEPARATE PAGE OR ATTACH A PHOTOCOPY OR BANK LETTER ON A SEPARATE PAGE



SECTION FIVE – AUTHORIZATION

By signing below, you confirm that the information that you have provided in this Agreement is true, complete and correct and you also hereby agree to the T&Cs set forth at http://www.instamed.com/im-online/terms_and_conditions.html, which is integral to, and forms a part of, this Agreement.

Authorized Signature

Name of Customer: _____ Date: _____

Signature: _____

Print Name: _____

Print Title: _____

Internal Use Only: Network Build Initials: _____