

ERA Reload Request form

Requestor: _____ Phone: _____

Check 1

Practice Name: _____

Insurance: _____

Check Number: _____

Check Amount: _____

Check Date: _____

Tax ID: _____

Submitter ID (if Relay): _____

NPI: _____

PTAN (if Medicare): _____

Check 2

Practice Name: _____

Insurance: _____

Check Number: _____

Check Amount: _____

Check Date: _____

Tax ID: _____

Submitter ID (if Relay): _____

NPI: _____

PTAN (if Medicare): _____

Please fax to 954-746-0402