CORE Payment & Remittance EFT Enrollment Data Rule

Version PR.2.0

November 2023

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Revision History for CORE Payment & Remittance EFT Enrollment Data Rule

Version	Revision	Description	Date
3.0.0	Major	CORE 380 EFT Enrollment Data Rule balloted and approved via CORE Voting Process.	June 2012
3.0.1	Minor	Non-substantive adjustments to the CORE-required Maximum EFT Enrollment Data Set to improve usability: • Further distinguished Data Elements that do not obligate the provider to submit any associated data but provide essential context for related Sub-elements • Addressed table formatting inconsistencies • Ensured consistency between data elements	July 2014
PR.1.0	Minor	• Non-substantive adjustments to support re-organization of operating rules into rule sets organized by business transaction (e.g., Eligibility & Benefits, Claim Status, etc.) rather than phase (e.g., Phase I, II, etc.) as approved by the CORE Board in 2019. • Operating rule naming, versioning and numbering methodologies updated to align with business transaction-based rule sets.	May 2020
PR.2.0	Major	• Draft substantive updates to the CORE-required Maximum EFT Enrollment Data Set and rule requirements to address current and emerging business needs.	November 2023

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1. Background Summary

The CORE Payment & Remittance Operating Rule Set addresses a range of operating rule requirements for both the HIPAA-adopted ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) Technical Report Type 3 Implementation Guide and associated errata (hereafter X12 v5010 835) transaction, also known as the Electronic Remittance Advice (ERA), and the Electronic Funds Transfer (EFT) by addressing operating rules related to the Nacha ACH (Automated Clearing House) CCD (Corporate Credit or Debit Entry) plus Addenda Record (hereafter CCD+) and the X12 835 TR3 TRN Segment (hereafter the CCD+ and X12 835 TR3 TRN Segment together are the Healthcare EFT Standards).[1]

Along with the ERA, the EFT or electronic payment made to the provider from the health plan furthers the automated processing of healthcare payments; paper checks and their manual processing are eliminated. This rule builds upon the other CORE Payment & Remittance Operating Rules by addressing a key barrier to the use of EFT by providers – a cumbersome and, in many cases, incomplete EFT enrollment data set that doesn't speak to the electronic needs of the system – and further enables the automated processing of healthcare payments.

Currently, healthcare providers or their agents[2] face significant challenges when enrolling to receive EFT payments from a health plan including:

- A wide variety in data elements requested for enrollment
- Variety in the enrollment processes and approvals to receive the EFT
- Absence of critical elements that would address essential questions regarding provider preferences on payment options

Conversely, health plans are also challenged by the effort and resources required to enroll providers and maintain changes in provider information over time. As a result, some plans may prioritize converting high volume claim submitters to EFT over converting lower volume submitters, even though the low volume submitters may account for most providers submitting claims.

Consistent and uniform operating rules enabling providers to quickly and efficiently enroll for EFT will help to mitigate:

- Complex and varied enrollment processes
- Variation in data elements requested for enrollment
- Lack of electronic access to enrollments
- Missing requests for critical elements that help address provider preference and system-wide automation

And provide for:

- Less staff time spent on phone calls and websites
- Increased ability to conduct targeted follow-up with health plans
- Broader adoption of EFT by providers
- An ability to ensure the enrollment process is coordinated with the next steps in payment process

[1] The CCD+ and X12 835 TR3 TRN Segment are adopted together as the Federal Healthcare EFT Standards in CMS-0024-IFC: Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

[2] One who agrees and is authorized to act on behalf of another, a principal, to legally bind an individual in particular business transactions with third parties pursuant to an agency relationship. Source: West's Encyclopedia of American Law, edition 2. Copyright 2008 The Gale Group, Inc. All rights reserved.

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In 2023, the CORE Enrollment Data Task Group evaluated opportunity areas for enhancing the CORE Payment & Remittance EFT & ERA Enrollment Data Rules. For ease of reference, new and updated rule language approved via this maintenance process is highlighted in gray.

2. Issue to be Addressed and Business Requirement Justification

It is a challenge for each provider, whether large or small, to complete enrollment and maintain changes to their banking information for EFT uniquely with each health plan. It is equally challenging for each health plan to collect and implement banking and identification information from every provider that they pay – moreover, common lessons learned on necessary requests to streamline the process are not being identified due to all this variation.

Additionally, provider bank account information may change frequently due to providers changing banks and changes in bank account information for providers that join and leave provider group organizations such as group practices. Providers seeking to enroll for EFT often face different enrollment formats and requirements. For many providers the enrollment process is cumbersome, time-consuming and can require the provider to initiate a relationship with a new bank and more than one bank.

2.1. Problem Space

During initial rule development, CORE EFT & ERA Subgroup Participant surveys and discussion identified significant barriers to achieving industry-wide rapid adoption of EFT and ERA; much of these findings were reiterated by CORE and Nacha research as well as research by other industry efforts. One of the key barriers identified is the challenge faced by providers due to the variances in the processes and data elements requested when enrolling in EFT with a health plan.

Due to the variations across health plans in the data elements requested, providers manually process enrollment forms for each plan to which they bill claims and from which they wish to receive an EFT payment. This results in unnecessary manual processing of multiple forms requesting a range of information – not necessarily the same – as noted by research findings – and, in the case when it is the same, often using a wide variety of data terminology for the same semantic concept (i.e., “Routing Number” vs. “Bank Routing Number”).

This inconsistent terminology for the same data element during EFT enrollment can cause confusion and incorrect data to be entered during the enrollment process resulting in further delays as manual processes are used to clarify the inaccurate data – telephone calls, faxes, emails and original enrollment documents are returned to the provider for review, correction and resubmission to the health plan.

The manual and time-consuming process required by many of the current enrollment processes today and the variety of enrollment forms and data requirements cost the industry time and money – and, in many cases, does not address the key items that are needed to use the EFT enrollment information to fully automate payments. As a consequence, providers are often reluctant to implement the EFT payment with many health plans, particularly those plans that have seemingly difficult or extensive requirements for enrollment.[3] It is well understood that EFT enrollment is not the only challenge with regard to provider adoption of EFT; however, it is one of the pieces of the puzzle and thus does need to be addressed, especially given the significant challenges that the other CORE Payment & Remittance Operating Rules are working to improve.

2.2. CORE Process in Addressing the Problem Space

To address the Problem Space associated with EFT enrollment, the initial CORE EFT & ERA Subgroup and its Work Group conducted a series of surveys, numerous Subgroup discussions and significant review of industry EFT enrollment forms and research related to existing industry initiatives (e.g.,

[3] CORE/Nacha White Paper: Adoption of EFT and ERA by Health Plans and Providers: A White Paper Identifying Business Issues and Recommendations for Operating Rules (2011).

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Workgroup for Electronic Data Interchange [WEDI], American Medical Association [AMA], etc.) to inform development of this CORE Payment & Remittance EFT Enrollment Data Rule.

In the ten years following initial publication of this rule, CORE conducted annual maintenance of the EFT Enrollment Data Set with no substantive adjustments made. In 2023, the CORE Enrollment Data Task Group launched a comprehensive review of the rule requirements and associated enrollment data set to address industry needs to drive greater EFT and ERA adoption and enhance security and fraud detection.

2.2.1.Research and Analysis of EFT & ERA Enrollment Forms

The CORE EFT & ERA Subgroup completed several research steps to determine a set of data elements to serve as a maximum data requirement for EFT enrollment during initial rule development. These key research steps included:

- Created source list for representative sample of EFT and ERA enrollment forms
- Using source list, obtained a representative sample of approximately 45 enrollment forms from eight key industry sectors (National Plans, Regional Plans, State Medicaid, Medicare, Clearinghouses, Worker's Compensation, Employer Owned [including Provider Owned], Third-Party Administrators)
- Identified frequency of data elements and key semantic concepts across source list enrollment forms and elements needing clarity; considered data elements utilized by external resources, e.g., the U.S. Postal Service, *Nacha Operating Rules*, etc.
- Using direct research findings and indirect sources (i.e., related white papers by WEDI, AMA, etc.), created a list of required data elements with definitions and other rule requirements using agreed-upon evaluation criteria
- Outlined the essential elements needed to address provider preferences and electronic transaction needs

CORE conducted substantial analysis to compare EFT enrollment forms from across the industry and follow up with specific industry sectors such as pharmacy. Using Subgroup-approved evaluation criteria, a set of universally necessary EFT enrollment data elements was identified by the CORE Participants as well as the detailed rule requirements around these EFT enrollment data elements. The CORE Participants agreed that these data elements represented the *maximum* set of data elements required for successful EFT enrollment; therefore, this rule addresses the maximum set of data elements required for providers enrolling for receipt of the EFT from a health plan.

2.2.1.1. Evaluation Criteria to Identify Required EFT Enrollment Data Elements

The following evaluation criteria were used by the Subgroup to identify the list of required EFT enrollment data elements using direct (e.g., EFT enrollment forms utilized by health plans and vendors) and indirect (e.g., white papers that address the topic of standardization of EFT enrollment) sources:

- Quantitative findings of research:
  - Include data elements that are frequently included across direct and indirect sources (e.g., elements included in 65% or more of all enrollment forms or research)
  - For data elements that have different terms used for the same semantic concept, e.g., meaning/intent, select one term for each data element (i.e., term selected would be used on 65% of forms, e.g., "Bank Transit Number" vs. "Bank Routing Number" vs. "Transit/Routing Number")
- Qualitative discussions for elements that are unclear in the quantitative findings, but are directly related to agreed-upon CORE EFT & ERA Subgroup high priority goals:
  - Identified strong business need to streamline the collection of data elements (e.g., Taxpayer Identification Number [TIN] vs. National Provider Identifier [NPI] provider preference)
  - Essential data for populating the Healthcare EFT Standards and the X12 v5010 835
  - Balance between time and resources (cost) to provide enrollment data versus necessity (benefit) to procure data element
  - Consistent with CORE Guiding Principles

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3. Scope

3.1. When the Rule Applies

This rule applies when a health plan or its agent is enrolling a healthcare provider or its agent for the purpose of engaging in the payment of healthcare claims electronically using the Healthcare EFT Standards.

3.2. CORE-required Maximum EFT Enrollment Data Element Set

The data elements identified in *CORE-required Maximum EFT Enrollment Data Set Companion Document* are the maximum number of data elements that a health plan or its agent may require a healthcare provider or its agent to submit to the health plan for the purpose of engaging in the payment of healthcare claims electronically.

These enrollment data elements represent a "controlled vocabulary" to provide a common, uniform and consistent way for health plans to collect and organize data for subsequent collection and use. A controlled vocabulary reduces ambiguity inherent in normal human languages (where the same concept can be given different names), ensures consistency and is potentially a crucial enabler of semantic interoperability.

The CORE-required Maximum EFT Enrollment Data Set (i.e., a controlled vocabulary) mandates the use of predefined and authorized terms that have been preselected by CORE Participants.

3.2.1. Data Element Group: Elements that May Need to be Requested Several Times

Several of the data elements in the *CORE-required Maximum EFT Enrollment Data Set Companion Document* can be logically related where each single discrete data element can form a larger grouping or a set of data elements that are logically related, e.g., a bank account number and a taxpayer identification number are typically requested together or should be. Such logical Data Element Groups are shown by assigning a Data Element Group identifier (e.g., DEG1, DEG2, etc.) to the discrete data element included in the set of logically related data elements.

Each Data Element Group (DEG) represents a set of data elements that may need to be collected more than once for a specific context, e.g., multiple bank accounts at a bank with different linked Taxpayer Identification Numbers (TIN)[4] or National Provider Identifiers (NPIs).[5] Examples of the DEGs are Provider Information, Provider Identifiers, and Financial Institution. Multiple uses of the same Data Element Group to collect the same data for another context are allowed by this rule and do not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.

3.2.2. Repeatable Data Elements

Bulk enrollment processes involve enrolling multiple providers simultaneously, necessitating the repetition of certain data elements for each provider record within a collective submission; for example, multiple National Provider Identifiers (NPIs) need to be enrolled under a single Taxpayer Identification Number (TIN). The CORE-required Maximum EFT Enrollment Data Elements are designed to be repeatable at the DEG or discrete data element level. Repetition of data elements to accommodate diverse enrollment contexts is allowed by this rule and does not constitute a non-conforming use of the CORE-required Maximum EFT Enrollment Set.

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[4] A Taxpayer Identification Number (TIN) is an identification number used by the Internal Revenue Service (IRS) in the administration of tax laws. It is issued either by the Social Security Administration (SSA) or by the IRS. A Social Security number (SSN) is issued by the SSA whereas all other TINs are issued by the IRS. https://www.irs.gov/individuals/international-taxpayers/taxpayer-identification-numbers-tin

[5] https://www.cms.gov/medicare/regulations-guidance/administrative-simplification

3.3. What the Rule Does Not Require

This rule does not require any health plan to:

- Engage in the process of paying for healthcare claims electronically
- Conduct either the X12 v5010 835 or the Healthcare EFT Standards transactions
- Combine EFT with ERA enrollment
- Re-enroll a provider if the provider is already enrolled and receiving the EFT

This rule does not prohibit or require a health plan from obligating a provider to agree to engage in EFT in order to receive an ERA.

3.4. CORE Process for Maintaining CORE-required Maximum EFT Enrollment Data Set

CORE recognizes that experience gained from EFT enrollment may indicate a need to modify the CORE-required EFT Enrollment Data Set to meet emerging industry needs and requires a process for soliciting feedback from the industry on a periodic basis.

CORE accepts maintenance submission requests for the CORE-required EFT Enrollment Data Set on a rolling basis and will convene the Enrollment Data Task Group if substantive submissions and critical needs are identified as defined below:

- Substantive submissions must meet the Enrollment Data Evaluation Criteria for Ongoing Maintenance.
- Critical needs are any adjustment necessary to resolve an issue prohibiting implementation of the current version of the EFT Enrollment Data Set for multiple implementers or to address a regulatory requirement.

If the Enrollment Data Task Group convenes to review a submitted substantive submission or critical needs and agrees to the substantive adjustment(s) to the EFT Enrollment Data Set, a notification is shared with the industry announcing the publication of an updated EFT Enrollment Data Set. Health plans or their business agents have twelve calendar months to update their electronic enrollment systems/forms and paper-based enrollment forms to comply with the published, updated version of the CORE-required EFT Enrollment Data Set. The timeframe starts on the date that CORE publishes the updated version of the Enrollment Data Set to the industry.

3.5. Outside the Scope of This Rule

This rule does not address any business relationship between a health plan and its agent, a healthcare provider and its agent, nor their financial institutions.

Outside the scope of this rule is:

- The need to collect other data for other business purposes and such data may be collected at the health plan's discretion
- The method or mechanism for how a health plan exchanges EFT data internally
- The method or mechanism for how a health plan collects EFT data externally

3.6. How the Rule Relates to other Operating Rule Sets

As with other CORE Operating Rules, general CORE policies apply to CORE Payment & Remittance Operating Rules.

3.7. Assumptions

A goal of this rule is to establish a foundation for the secure, successful, and timely enrollment of healthcare providers by health plans to engage in the payment of healthcare claims electronically.

The following assumption applies to this rule:

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- This rule is a component of the larger set of CORE Payment & Remittance Operating Rules; as such, all the CORE Guiding Principles apply to this rule and all other rules.
- To further secure the ACH Network, Nacha, which manages the development, administration, and governance of the ACH Network, continuously enhances its Operating Rules to reduce the opportunity for fraud. Any user of the ACH Network is required to adhere to the Nacha Operating Rules, including Health Plans who originate EFT to providers.

4. Rule Requirements

4.1. Requirements for a Health Plan, its Agent or Vendors Offering EFT Enrollment

A health plan or its agent or vendors offering EFT enrollment must comply with all requirements specified in this rule when collecting from a healthcare provider or its agent the data elements needed to enroll the healthcare provider for the payment of healthcare claims electronically.

4.2. CORE-required Maximum EFT Enrollment Data Elements

A health plan or its agent or vendors offering EFT enrollment is required to collect no more data elements than the maximum data elements defined in the *CORE-required Maximum EFT Enrollment Data Set Companion Document*.

The *CORE-required Maximum EFT Enrollment Data Set Companion Document* lists all the CORE-required maximum Individual Data Elements organized by categories of information (Data Element Groups), e.g., Provider Information, Provider Identifiers Information, Federal Agency Information, Retail Pharmacy Information, Financial Institution Information and Submission Information. Both the Individual Data Element name and its associated description must be used by a health plan or its agent or vendors offering EFT enrollment when collecting EFT enrollment data either electronically or via a manual paper-based process. The Individual Data Element Name and its associated description must not be modified.

Data Element Groups represent a set of data elements that may need to be collected more than once for a specific context (Reference §3.2.1 and §3.2.2 above). Multiple uses of the same DEG to collect the same data for another context are allowed by this rule and do not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.

A DEG may be designated as required or optional for data collection. Within each DEG, Individual Data Elements are designated as required or optional for data collection.

- When a DEG is designated as required, all the Individual Data Elements designated as required within the DEG must be collected by the health plan; Individual Data Elements designated as optional may be collected depending on the business needs of the health plan.
- When a DEG is designated as optional, the collection of the optional DEG is at the discretion of the health plan. When a health plan exercises its discretion to collect an optional DEG, any included Individual Data Element designated as required must be collected.
- Some required or optional Individual Data Elements are composed of one or more Sub-elements, where a Sub-element is designated as either required or optional for collection. When a health plan collects an optional Individual Data Element that is composed of one more optional Sub-element, the optional Sub- element may be collected at the discretion of the health plan. When a health plan collects a required Individual Data Element that is composed of one or more optional Sub-elements, the optional Sub-element may be collected at the discretion of the health plan.

Not collecting an Individual Data Element identified as optional does not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.

The data elements in the *CORE-required Maximum EFT Enrollment Data Set Companion Document* are for new enrollments. When an enrollment is being changed or cancelled, the health plan must make available to the provider instructions on the specific procedure to accomplish a change in their enrollment or to cancel their enrollment.

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4.3. CORE Master Template for Collecting EFT Enrollment Data

4.3.1. Master Template for Manual Paper-Based Enrollment

The name of the health plan or its agent or the vendor offering EFT and the purpose of the form will be on the top of the form, e.g., Health Plan X: Electronic Funds Transfer (EFT) Authorization Agreement.

A health plan or its agent or a vendor offering EFT is required to use the format, flow and data set including data element descriptions of the CORE-required Maximum EFT Enrollment Data Set as the CORE Master EFT Enrollment Submission form when using a manual paper-based enrollment method. All CORE-required EFT Enrollment data elements must appear on the paper form in the same order as they appear in the *CORE-required Maximum EFT Enrollment Data Set Companion Document*.

A health plan or its agent cannot revise or modify:

- The name of a CORE Master EFT Enrollment Data Element Name
- The usage requirement of a CORE Master EFT Enrollment Data Element
- The Data Element Group number of a CORE Master EFT Enrollment Data Element

Beyond the data elements and their flow, a health plan or its agent must:

- Develop and make available to the healthcare provider or its agent specific written instructions and guidance for the healthcare provider or its agent when completing and submitting the enrollment form, including when using paper
- Provide a number to fax and/or a U.S. Postal Service or email address to send the completed form
- Include contact information for the health plan, specifically a telephone number and/or email address to send questions
- Include authorization language for the provider to read and consider
- Include a section in the form that outlines how the provider can access online instructions for how the provider can determine the status of the EFT enrollment
- Clearly label any appendix describing its purpose as it relates to the provider enrolling in EFT
- Inform the provider that it must contact its financial institution to arrange for the delivery of the CORE- required Minimum CCD+ data elements needed for reassociation of the payment and the ERA. *See CORE Payment & Remittance (CCD+/835) Reassociation Rule.*

4.3.2. Master Template for Electronic Enrollment

When electronically enrolling a healthcare provider in EFT, a health plan or its agent must use the CORE Master EFT Enrollment Data Element Name and Sub-element Name as specified in the *CORE-required Maximum EFT Enrollment Data Set Companion Document* without revision or modification.

When using an XML-based electronic approach, the Data Element Name and Sub-element Name must be used exactly as represented in the table enclosed in angle brackets (i.e., < >) for the standard XML element name and all spaces replaced with an underscore [_] character e.g., <Provider_Address>.

As noted below in §4.4, a health plan or its agent or vendors offering EFT enrollment will offer an electronic way for provider to complete and submit the EFT enrollment. A health plan may use a web-based method for its electronic approach to offering EFT enrollment. The design of the website is restricted by this rule only to the extent that the flow, format and data set including data element descriptions established by this rule must be followed.

4.4. CORE Electronic Safe Harbor for EFT Enrollment to Occur Electronically

This rule provides an EFT enrollment “Electronic Safe Harbor” by which health plans, healthcare providers, their respective agents, application vendors and intermediaries can be assured will be supported by any trading partner. This EFT Enrollment Data Rule specifies that all health plans and their respective agents must implement and offer to any trading partner (e.g., a healthcare provider) a

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secured[6] electronic method (actual method to be determined by health plan or its agent) and process for collecting the CORE-required Maximum EFT Enrollment Data Set. As an EFT enrollment "Safe Harbor," this rule:

- **DOES NOT** require health plans or their agents to discontinue using existing manual and/or paper-based methods and processes to collect the CORE-required Maximum EFT Enrollment Data Set.
- **DOES NOT** require health plans or their agents to use ONLY an electronic method and process for collecting the CORE-required Maximum EFT Enrollment Data Set.
- **DOES NOT** require an entity to do business with any trading partner or other entity.

CORE expects that in some circumstances, health plans or their agents may agree to use non-electronic methods and mechanisms to achieve the goal of the collection of EFT enrollment data – and that provider trading partners will respond to using this method should they choose to do so.

However, the electronic EFT enrollment "Safe Harbor" mechanism offered by a health plan and its agent MUST be used by the health plan or its agent if requested by a trading partner or its agent. The electronic EFT enrollment "Safe Harbor" mechanism is not limited to single entity enrollments and may include a bulk enrollments. If the health plan or its agent does not believe that this CORE EFT Enrollment Safe Harbor is the best mechanism for a particular trading partner or its agent, it may work with its trading partner to implement a different, mutually agreeable collection method; however, if the trading partner insists on conducting EFT Enrollment electronically, the health plan or its agent must accommodate that request. This clarification is not intended in any way to modify an entity's obligation to exchange electronic transactions as specified by HIPAA or other Federal and state regulations.

4.5. Instructions for Electronic Enrollment

A health plan must develop and make available to the healthcare provider or its agent specific written instructions and guidance for the healthcare provider or its agent when providing and submitting the data elements in the *CORE-required Maximum EFT Enrollment Data Set Companion Document*. The health plan's specific instructions and guidance are not addressed in this rule.

4.6. Notifications for Electronic Enrollment Submissions

4.6.1. Confirmation of Receipt of an Electronic Enrollment Submission

When a provider clicks "submit", or a similar command button on an electronic enrollment form after completing all data fields, the system must return a submission receipt in 24 hours or less, indicating to the provider that the completed enrollment form was successfully received and information about the "next steps" for processing the enrollment. This timeframe requirement must be met at least 90 percent of the time per calendar month.

This confirmation of receipt should be provided for initial enrollment, disenrollment and enrollment changes. Examples of such information may include, but not limited to:

- Option to print and save a PDF
- View the enrollment status
- The status or an update of a previously submitted request
- Assignment of a transaction or reference control number
- A detailed timestamp, potentially including date, time and time zone of the submission

4.6.2. Confirmation of Completed Processing of an Electronic Enrollment Submission

When a health plan or its agent successfully processes an enrollment, disenrollment or enrollment change it must send an electronic notification to the provider to communicate that the request was

[6] Electronic methods to secure the process for collecting the CORE-required Maximum EFT Enrollment Data Set could include user authentication measures including, multi-factor authentication, the use of security questions, etc..

completed in 2 weeks or less. This timeframe requirement must be met at least 90 percent of the time per calendar month.

The notification should provide information about enrollment status. Examples of such information may include, but not limited to:

- Status of the enrollment, disenrollment or change
- Effective date
- Estimated date of first EFT and/or ERA transaction delivery; or date of last if a disenrollment

4.7. Disclosure of Applicable EFT Fees

A health plan or its agent must disclose any associated fees for receiving EFT payments that are incurred to the provider as part of the EFT enrollment process when such fees are known.

4.8. Alternative Electronic Payments Opt-in and Opt-out

A health plan or its agent must provide guidance on how a provider can either opt in or opt out of non-EFT electronic payment methods or additional value-added services, such as virtual credit cards, if offered. The guidance is to be determined by the health plan or its agent.

4.9. Time Frame for Rule Compliance

Not later than the date that is six months after the compliance date specified in any Federal regulation adopting this rule, a health plan or its agent that uses a paper-based form to collect and submit the CORE-required Maximum EFT Enrollment Data Set must convert all its paper-based forms to comply with the data set specified in this rule. Should such paper forms be available at provider's offices or other locations, it is expected that such paper-based forms will be replaced.

If a health plan or its agent does not use a paper-based manual method and process to collect the CORE-required Maximum EFT Enrollment Data Set as of the compliance date specified in any Federal regulation adopting this rule, it is not required by this rule to implement a paper-based manual process on or after the compliance date.

It will be expected that all electronic EFT enrollment will meet this rule requirement and that of the compliance date, and that the health plan or its agent will inform its providers that an electronic option is now available, if not previously available.

5. Conformance Requirements

Conformance with this rule is considered achieved when all the required detailed step-by-step test scripts specified in the Payment & Remittance CORE Certification Test Suite are successfully passed.

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