BLUE CROSS BLUE SHIELD ALABAMA
PRE-ENROLLMENT INSTRUCTIONS - 00510

HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is 2 weeks.

WHAT FORM(S) SHOULD I COMPLETE?

- EDI Enrollment Request for Existing Submitter ID
  - EDI Enrollment Request Additional Providers – ONLY required if more room was needed to add providers and MUST be submitted with the EDI Enrollment Request for Existing Submitter ID form.
- EDI Enrollment Request for Electronic Remittance (835) Files – ONLY required if you want to Office Ally to receive your Electronic Remits on your behalf.

WHO CAN SIGN THE FORM(S)?

- Owner or authorized personnel.

WHERE SHOULD I SEND THE FORM(S)?

- The form(s) can be faxed to EDI Services at (205) 733-7362 or emailed to EDIEnrollment@bcbsal.org.

HOW DO I CHECK STATUS?

- EDI Approvals are only sent to Office Ally. You may contact Office Ally at 360-975-7000, option 1 to confirm .

To complete your enrollment follow instructions on the "Note to My Clients Plus users" page and FAX info requested. We will forward to our clearinghouse and notify you by email when your registration is complete.

your approval.

WHAT PROVIDER NUMBERS DO I USE?

- NPI Number
- Tax ID

Note to My Clients Plus Users:

Once you have confirmed with the Insurance Payer your billing NPI/ Provider number is linked to Office Ally, please fax the following information to 888-653-7115.

- **Please label with "My Clients Plus" on top**
- **Provider/Practice Name as pre-enrolled with the Insurance Payer**
- **Fed Tax ID**
- **Billing NPI**
- **Insurance Payer (including State if BCBS, Medicare or Medicaid).**
- **The statement "I have verified my Provider ID has been linked to Office Ally with the Insurance Payer".**
- **Provider email address where you can be notified of setup completion.**
- **For Noridian Pre-Enrollments Please Also Include: Submitter number**
- **For Tufts Health Plan Pre-Enrollments, please also include the billing address that was setup with the payer and if it is for a professional or institutional claim.**

Revised 10/1/2012

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

EDI Enrollment Request for *EXISTING* Submitter ID

Existing Submitter ID: OALLY001

Section I.

PRACTICE/FACILITY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Section II.

VENDOR/CLEARINGHOUSE NAME: Office Ally

CONTACT NAME: Customer Support BLUE CROSS VENDOR ID: 709A

Section III.

Indicate the requested transaction(s):
- ☒ 837 – claim (batch)
- ☐ 270/276/278 –eligibility, claim status, and referral (real-time)

Section IV. *(Continue provider list onto page 2 if additional space is needed.)*

NAME OF PROVIDER	PROVIDER NPI	TAX ID

Blue Cross will assign provider passwords and forward to the vendor.

Completed form(s) should be faxed to EDI Services at 205 733-7362 or emailed to EDIEnrollment@bcbsal.org.

The undersigned hereby:

- Represents and warrants that he or she has full power and authority to execute this agreement on behalf of the health care provider identified in Section I (Provider) and to bind the Provider to the terms and conditions of this agreement;
- Authorizes Blue Cross and Blue Shield of Alabama (BCBSAL) (1) to disclose protected health information to the business associate identified in Section II (Business Associate); and (2) to return Provider passwords to Business Associate;
- Agrees to notify BCBSAL if the Business Associate changes;
- Agrees that Provider will be responsible for all electronic transactions submitted to BCBSAL by Provider, its employees, and its agents;
- Agrees that BCBSAL has the right to audit and confirm information submitted by or on behalf of Provider and shall have access to all original source documents and medical records related to Provider's submissions. All incorrect payments shall be adjusted in accordance with BCBSAL guidelines;
- Agrees that Provider will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all data from improper access; and
- Agrees to establish and maintain procedures and controls so that information concerning Blue Cross subscribers, or any information obtained from Blue Cross, shall not be used by agents, officers, or employees of the billing service except as provided by Blue Cross.

_____ _____

Authorized Representative of Provider Date

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EDI Enrollment Request
Additional Providers

This **optional** form must be accompanied by page 1 of a ***New*** or ***Existing Submitter ID*** form.

Submitter ID: OALLY001

NAME OF PROVIDER(S)	PROVIDER NPI	TAX ID

The undersigned hereby:

- Represents and warrants that he or she has full power and authority to execute this agreement on behalf of the health care provider identified in Section I (Provider) and to bind the Provider to the terms and conditions of this agreement;
- Authorizes Blue Cross and Blue Shield of Alabama (BCBSAL) (1) to disclose protected health information to the business associate identified in Section II (Business Associate); and (2) to return Provider passwords to Business Associate;
- Agrees to notify BCBSAL if the Business Associate changes;
- Agrees that Provider will be responsible for all electronic transactions submitted to BCBSAL by Provider, its employees, and its agents;
- Agrees that BCBSAL has the right to audit and confirm information submitted by or on behalf of Provider and shall have access to all original source documents and medical records related to Provider's submissions. All incorrect payments shall be adjusted in accordance with BCBSAL guidelines;
- Agrees that Provider will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all data from improper access; and
- Agrees to establish and maintain procedures and controls so that information concerning Blue Cross subscribers, or any information obtained from Blue Cross, shall not be used by agents, officers, or employees of the billing service except as provided by Blue Cross.

Authorized Representative of Provider

Date

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

EDI Enrollment Request for Electronic Remittance (835) Files

Section I:

PRACTICE/FACILITY NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

Section II:

835 VENDOR/CLEARINGHOUSE NAME: Office Ally

CONTACT NAME: Customer Service BLUE CROSS VENDOR ID: 709A

Section III:

Electronic Remittance Notices are formatted in the mandated HIPAA version and will be uploaded by Blue Cross to the specified FTP directory each Monday for the following Thursday's payment. Remittance files are purged from the FTP server after 45 days.

Required Information

Indicate the FTP directory where 835 remittance files should be delivered: OALLY001

Indicate the applicable line of business:
☐ Institutional ☒ Professional/Dental

Optional Information

☐ Check here if a dial-up connection is needed.

***NOTE**: A dial-up connection is not required if the FTP server is accessed through the internet or a frame relay connection.*

Section IV:

PRACTICE/FACILITY NAME	PAYEE NPI* (NPI receiving payment)	TAX ID

***The Payee NPI will be the group NPI if the provider is part of a group or the individual NPI if the provider is a sole practitioner.**
NOTE: If the provider is part of a group, it is not necessary to enroll the Payee NPI/tax ID combination more than once. All providers will be included in the 835 remittance file if they are associated with the Payee NPI/tax ID combination listed in Section IV.

Completed form should be faxed to EDI Services at 205 733-7362 or emailed to EDIEnrollment@bcbsal.org.

The undersigned hereby:

- Represents and warrants that he or she has full power and authority to execute this agreement on behalf of the health care provider identified in Section I (Provider) and to bind the Provider to the terms and conditions of this agreement;
- Authorizes Blue Cross and Blue Shield of Alabama (BCBSAL) (1) to disclose protected health information to the business associate identified in Section II (Business Associate); and (2) to return Provider passwords to Business Associate;
- Agrees to notify BCBSAL if the Business Associate changes;
- Agrees that Provider will be responsible for all electronic transactions submitted to BCBSAL by Provider, its employees, and its agents;
- Agrees that BCBSAL has the right to audit and confirm information submitted by or on behalf of Provider and shall have access to all original source documents and medical records related to Provider's submissions. All incorrect payments shall be adjusted in accordance with BCBSAL guidelines;
- Agrees that Provider will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all data from improper access; and
- Agrees to establish and maintain procedures and controls so that information concerning Blue Cross subscribers, or any information obtained from Blue Cross, shall not be used by agents, officers, or employees of the billing service except as provided by Blue Cross.

_____ _____

Authorized Representative of Provider Date