

Alabama Blue Cross Blue Shield – BS054 Payer Agreement Instructions

Are you set up with the Payer?

This enrollment form is for submitters who have completed all necessary arrangements with this payer. Although payer requirements vary, please be sure to:

- Register your NPI with this Payer
- Contract with this Payer, if needed. You must have a valid Provider Identification Number (PIN).

In addition there may be other EDI payer requirements. For more specific information please contact the Payer's Provider Relations Department.

McKesson Requirements

Complete the Exhibit B & Carrier Agreement Tracking Form (CAT Form) and fax to the McKesson EDI Enrollment Department at: 800-633-4763. These forms are included in the next two pages.

- This form is used to update the provider/practice profile with the correct information so that approval can be obtained from the payer for electronic submission.
- This form can also be used if you are making changes to an existing setup for this payer, i.e. change to Provider PIN or NPI.
- Please ensure that any tracking information is included. This is used when contacting the payer for approvals.
- Failure to complete this form and submit to McKesson may delay the processing of this payer with the clearinghouse.
- The Exhibit B & CAT Form does not go to the payer, only to McKesson EDI Enrollment.

Payer Enrollment

- Some payers require original forms.
- If the payer accepts copies, be sure to include all pages of the agreement and verify that they are legible.
- Submit one agreement per Provider Group ID
- Incomplete or incorrect agreements may be denied or returned by the payer and may require the enrollment process be started from the beginning.
- Approvals can take 3 – 4 weeks.

Payer Approvals

- In some cases the payer will send the approval to the provider/practice instead of notifying the clearinghouse. If you receive payer approval please let us know by faxing a copy to EDI Enrollment at: 800-633-4763.
- DO NOT transmit claims to this payer until you have verified with the Enrollment Department that the clearinghouse has received and updated the approval in their system.

**Guidelines for completing: Alabama Blue Cross Blue Shield – BS054
Payer Agreement Instructions**

When you have completed this agreement please fax or mail to the payer at:

Fax: (205) 733-7362

Mailing Address:

EDI Services
P.O. Box 12566
Birmingham, AL 35202-2566

Electronic Data Interchange (EDI) Setup Requirements – For Firsts Time and Existing EDI Customers

Section	Instructions
Existing Submitter ID	Enter your BCBS Alabama ID. If you do not have an existing ID with this payer then you will need to complete “Request for New Submitter ID” in order to be set up with this payer.
Section I	Complete all fields
Section II and III	Pre-filled
Section IV	Use this section to list providers associated or being added to your submitter ID. Use page 2, if needed, for additional fields.

Electronic Data Interchange (EDI) Agreement Form – For First Time EDI Customers

Section	Instructions
Provider's Name/ Title	Self explanatory
Provider Number	BCBS Provider ID
Address/City/State/Zip	Self explanatory
By	<i>Original</i> signature of the provider or authorized representative is required. Stamped signatures are not acceptable.
Title	Title of person signing the agreement
Date	Date signed

Once the BCBS form(s) has been completed and faxed/mailed to the payer, please complete the **McKesson Ex. B & CAT Form** and fax to:

McKesson EDI Enrollment

800-633-4763

FAX TO 1-800-633-4763

Each provider in the practice planning to submit health care transactions electronically must be included in this enrollment form. If a provider has more than one office, please complete a separate form for each office.

PLEASE CHECK ONE OF THE BELOW CHOICES

- Add on Provider (Adding Provider to existing McKesson Account)*
- Add on Payer (Adding Payer to a Provider with an existing McKesson account)**
- Update or Change to a Provider’s PIN or Group Number for requested payers.**

*Adding a provider to an account may result in a pricing increase depending on the pricing plan you are currently on. If you are not sure what pricing plan you are on, please contact your Value Added Reseller or the EDI Enrollment Department at 1-800-689-4550

** If adding or changing information regarding an Insurance Carrier/Payer for an existing provider you must also complete the Carrier Agreement Tracking Form (CAT Form) which is page 2 of this document.

Client ID: _____ Practice Tax-ID: _____

Practice Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____ VAR # _____

Telephone: _____ Facsimile: _____

Billing service name: _____ Billing Service Tax

ID: _____ (If applicable) applicable) (If applicable)

<i>First Name</i>	<i>Last Name</i>	<i>Credential</i>	<i>Specialty</i>	<i>Individual NPI</i>	<i>Group NPI</i>

Practice Name:	
Practice Tax ID:	

Please include this form with the Exhibit B. Complete this form for each provider in the practice after all agreements have been forwarded to the respective carriers. You may wish to retain a copy of this form for your records.

In the grid below, please enter **ALL** of the requested information for each carrier/payer to enroll. **This is critical information that is required to complete your enrollment process. The clearinghouse cannot contact payers to confirm your approval for electronic transmission without first knowing the date agreements were mailed to them.**

***Please indicate the appropriate Payer ID Number below each payer as indicated in the payer directory. The Phoenix Payer Directory can be found online at http://www.lytec.com/download/Phoenix_Payer_List.pdf for Lytec users or at http://www.medisoft.com/download/Phoenix_Payer_List.pdf for Medisoft users**

Payer	Provider #1	Provider #2	Provider #3
	Name:	Name:	Name:
	Ind NPI:	Ind NPI:	Ind NPI:
	Group NPI:	Group NPI:	Group NPI:
Medicare	Ind #	Ind #	Ind #
	Grp #	Grp #	Grp #
Medicaid	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
BCBS	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
TriCare	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
RR Medicare	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
Other	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
Other	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #

Please note the date on which you sent each carrier agreement to the carrier and the service used to send it (i.e., UPS, FedEx, Airborne Express, etc.) as well as a package tracking number, if applicable.

Carrier/Payer Name	Date Mailed	Service Used	Tracking Number



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

**EDI ENROLLMENT REQUEST
FOR EXISTING SUBMITTER ID**

EXISTING SUBMITTER ID: PROXYMED

Section I.

PRACTICE/FACILITY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: (____) _____ CONTACT NAME: _____

FAX NUMBER: (____) _____ E-MAIL: _____

Section II.

VENDOR/CLEARINGHOUSE/BILLING SERVICE NAME: MedAvant Healthcare Solutions

TELEPHONE: (800)_792-5256 Option 1 CONTACT NAME: Enrollment Department

FAX NUMBER: (404)_877-3324 E-MAIL: provider.enrollment@medavanthealth.com

Indicate the requested transactions: (Select as many as appropriate.)

- 837 Dental Transaction
- 837 Institutional Transaction
- 837 Professional Transaction
- 835 Remittance Transaction
- 278 Referral/Precert Transaction
- 270/276 Eligibility / Claim Status Transaction
- Assign 270/276 password by:
 - Submitter ID
 - Provider ID

Not required until new version adopted

Indicate the ANSI format:

- 837 _____
- 835 _____
- 270/ _____
- 276 _____
- 278 _____

Anticipated Implementation Date:

A completed EDI Enrollment form is required for each provider and must accompany this request.

Section IV.

NAME OF PROVIDER(S) YOU ARE ADDING TO CURRENT SUBMITTER NUMBER	PROVIDER NUMBER	COMMON PAY NUMBER	TAX ID

If there are **additional** providers, please complete page 2 of this form.

Blue Cross and Blue Shield of Alabama assigns provider passwords.
Passwords assigned by a provider or vendor will not be accepted.

Please fax to EDI Services at 205 733-7362.

The undersigned hereby:

- Authorizes Blue Cross and Blue Shield of Alabama to disclose protected health information to the business associate identified in Section II;
- Authorizes Blue Cross and Blue Shield of Alabama to return provider passwords to the business associate identified in Section II; and,
- Agrees to notify Blue Cross and Blue Shield of Alabama if the business associate identified in Section II changes.

Authorized Signature

Date

The user of this form agrees to 1.) Use sufficient security procedures to ensure that all transmission of documents are authorized and protect all subscriber-specific data from improper access and 2.) 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.



ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

PLEASE CHECK APPLICABLE LINE OF BUSINESS:

INSTITUTIONAL
PROFESSIONAL

The provider agrees to the following provisions for submitting physician, supplier or facility transactions electronically to Blue Cross and Blue Shield of Alabama further referred to as Blue Cross.

A. The Provider Agrees:

1. That it will be responsible for all electronic transactions submitted to Blue Cross by itself, its employees, or its agents.
2. That it will not disclose any information concerning a Blue Cross beneficiary to any other person or organization, except Blue Cross, without the express written permission of the beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Blue Cross, or as required by State or Federal law.
3. That it will submit claims only on behalf of those Blue Cross beneficiaries who have given their written authorization to do so, and to certify that required beneficiary signatures, or legally authorized signatures on behalf of beneficiaries, are on file.
4. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect at least the following information:
 - Beneficiary's name,
 - Beneficiary's health insurance claim number,
 - Date(s) of service,
 - Diagnosis/nature of illness, and
 - Procedure/service performed
5. That Blue Cross has the right to audit and confirm information submitted by the provider and shall have access to all original source documents and medical records related to the provider's submissions, including the beneficiary's authorization and signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to the applicable provisions of the Social Security Act, Federal regulations, and Blue Cross guidelines.
6. That it will ensure that all claims for Blue Cross primary payment have been developed for other insurance involvement and that Blue Cross is the primary payer.
7. That it will submit claims that are accurate, complete, and truthful.
8. That it will retain all original source documentation and medical records pertaining to any such particular Blue Cross claim for a period of at least 6 years, 3 months after the bill is paid.
9. That it will affix the Blue Cross-assigned unique identifier number of the provider on each claim electronically transmitted to Blue Cross.
10. That the Blue Cross-assigned unique identifier number constitutes the provider's legal electronic signature and constitutes an assurance by the provider that services were performed as billed.
11. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.
12. That the submission of such claims is a claim for payment under the Blue Cross program, and that anyone who misrepresents or falsifies or caused to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this Agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law.
13. That it will establish and maintain procedures and controls so that information concerning Blue Cross beneficiaries, 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.
14. That it will research and correct claim discrepancies.
15. That it will notify Blue Cross if any transmitted data are received in an unintelligible or garbled form.



ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM
PLEASE CHECK APPLICABLE LINE OF BUSINESS:

INSTITUTIONAL
PROFESSIONAL

Blue Cross Agrees To:

1. Make available to the provider an acknowledgement of claim receipt.
2. Affix the Blue Cross payer ID as its electronic signature, on each remittance advice sent to the provider.
3. Ensure that payments to providers are timely in accordance with contract policies.
4. Ensure that Blue Cross may not require the provider to purchase any or all electronic services from Blue Cross or from any subsidiary of Blue Cross or from any company for which Blue Cross has an interest. Blue Cross will make alternative means available to any electronic biller to obtain such services.
5. Ensure that all Blue Cross electronic billers have equal access to any services that Blue Cross requires of electronic submitters to make available to providers or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services Blue Cross sells directly, indirectly, or by arrangement.
6. Notify the provider if any transmitted data are received in an unintelligible or garbled form.

NOTICE:

Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by Blue Cross under this document.

This document shall become effective when signed by the provider. The responsibilities and obligations contained in this document will remain in effect as long as Blue Cross electronic claims are submitted to Blue Cross. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

B. Signature:

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Provider's Name: _____ Provider Number: _____

Title: _____

Address: _____

City / ST / Zip: _____

By: _____
(print) (signature)

Date: _____

MAIL OR FAX THIS FORM WITH SIGNATURE(S) TO:

EDI Services
P.O. Box 12566
Birmingham, AL 35202-2566
Fax 205 733-7362