



Empowering Healthcare

ERA Payer Agreement Instructions for Nevada Blue Shield – Payer ID BS019

Important Notes

ERA transactions are available as an additional McKesson contracted service. To add ERAs to your contract please contact your McKesson Sales person or Value Added Reseller. ERAs must be part of your McKesson contract BEFORE requesting ERA service through the McKesson EDI Enrollment Department.

Electronic Funds Transfer (EFT) is an arrangement between the Physician/Provider and the Payer. McKesson does not manage or transmit EFTs.

Before receiving ERAs for Nevada Blue Shield the Physician/Provider must:

- Be processing claims electronically with this payer
- Contract with McKesson for All Payer ERA service
- Complete an ERA Enrollment Request Form
- Complete Nevada Blue Shield's Electronic Remittance Advice Enrollment Form.

Guidelines for completing: Nevada Blue Shield Electronic Remittance Advice and EFT Enrollment Form:

- Complete all required fields
- Submit one ERA/EFT Payer Agreement for each Physician/Group Tax ID.
- Once the agreement is open in Adobe Reader you can type information onto the form.
- Complete Attachment A-1 of the Anthem ERA/EFT Form.
- Provider / billing provider name and Tax ID.
- Address/city/state/zip and Phone Number.
- Contact name / title.
- Authorized signature / signer name / title / phone / date.
- Complete Attachment B-1 of the Anthem ERA/EFT Form if EFT is desired.
- Prepare copy of provider Explanation of Payment (EOP) with payee id visible.
- Prepare authorization letter (letter must be on company letterhead).
- Body must reference MedAvant Healthcare Solutions as authorized to receive ERA.
- List tax id of billing provider / group.
- Forward original ERA agreement along with your McKesson ERA Enrollment Request Form to the Enrollment Team for processing.
- Please allow up to 30 days for approval and receipt of Nevada Blue Shield ERA.

Fax completed Nevada Blue Shield ERA Agreement and McKesson ERA Enrollment Request Form to:

McKesson EDI Enrollment

800-633-4763



ERA/EFT Enrollment Form

Please Mail All Completed Forms to:
Anthem Blue Cross and Blue Shield of CO & NV
ATTN: EDI Services CO0111-1134
700 Broadway, Denver, CO 80273
EDI Technical Support: (303) 831-2626, (800) 332-7575
Fax: (303) 764-7057
Incomplete enrollment packages will cause delay.

Complete this form to request scheduling for implementation of the ERA/EFT for the provider indicated below after this facility's eligibility for these services has been verified. **A separate form is required for each Tax Identification Number.**

Provider Name: _____

Tax ID Number: _____

Physical Address: _____ City: _____ State: _____ ZIP: _____

Contact Name: _____ Title: _____ Phone: _____

**I WILL BE USING ONE OF THE FOLLOWING TO TRANSLATE/PRINT THE ERA FILE:
CHECK ONE BOX ONLY**

INTERNAL TRANSLATOR SOFTWARE VENDOR _____

By submission of this form to Anthem Blue Cross and Blue Shield of CO & NV, I authorize implementation of the services requested above for this facility and agree to the following:

1. PROVIDER hereby requests Electronic Remittance Advice and/or Electronic Funds Transfer ("ERA/EFT") for Anthem Blue Cross and Blue Shield of CO & NV claims.
2. PROVIDER shall assign a primary contact person for ERA/EFT, with responsibilities for scheduling and implementation.
3. If PROVIDER implements ERA capability other than directly with Anthem Blue Cross and Blue Shield of CO & NV, PROVIDER shall authorize the Billing Service, EMC vendor or other party, in writing as the agent of PROVIDER. Said agent shall be authorized to schedule and implement ERA for PROVIDER. PROVIDER shall further authorize in writing the release of all claims payment data and applicable financial information to PROVIDER's agent.
4. **PROVIDER agrees that, if PROVIDER uses an agent to implement ERA, PROVIDER shall give Anthem Blue Cross and Blue Shield of CO & NV a letter ("Release Letter") signed by a duly authorized representative of PROVIDER, on PROVIDER's letterhead, stating (1) the name and address of PROVIDER's agent and (2) the scope of the agent's authority and (3) that said agent is both aware of, and has agreed to be bound by, all applicable state and federal laws and regulations with regard to patient confidentiality.**
5. PROVIDER is , is not currently using a billing agent. if PROVIDER is currently using a billing agent, PROVIDER's Release Letter is attached and is incorporated by reference.
6. PROVIDER understands and agrees that a new Release Letter shall be provided to Anthem Blue Cross and Blue Shield of CO & NV whenever PROVIDER changes or terminates PROVIDER's agent, as applicable.
7. PROVIDER hereby acknowledges that hard copy Remittance Advice shall be discontinued **thirty (30) days from the date of the first ERA file transfer.**
8. PROVIDER hereby represents and warrants that its duly authorized representative signs this request for Commercial ERA/EFT.

The CEO or CFO of this facility must sign this form.

PRINT NAME: _____ **SIGNATURE:** _____

TITLE: _____ **DATE:** _____ **PHONE:** _____

ATTACHMENT A-1



Direct Deposit Authorization

Please Mail All Completed Forms to:
Anthem Blue Cross and Blue Shield of CO & NV
ATTN: EDI Services CO0111-1134
700 Broadway, Denver, CO 80273
EDI Technical Support: (303) 831-2626, (800) 332-7575
Fax: (303) 764-7057
Incomplete enrollment packages will cause delay.

Anthem Blue Cross and Blue Shield of CO & NV Systems is hereby authorized to deposit payments for claims to the account listed below. **A voided check or deposit slip is required for the account receiving the direct deposit.**

PROVIDER NAME:	PAYEE ID NUMBER(S)
ADMINISTRATIVE CONTACT:	TAX ID NUMBER:
TITLE:	PHONE NUMBER:

BANK INFORMATION

NAME ON BANK ACCOUNT	
ACCOUNT TYPE	<input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS
BANK NAME	BRANCH NAME
BANK ADDRESS	BANK PHONE NUMBER
ACCOUNT NUMBER	TRANSIT/ABA NUMBER

An authorized signer on the bank account must sign this form

PRINT NAME: _____	SIGNATURE: _____
TITLE: _____	PHONE NUMBER: _____
DATE SIGNED: _____	FAX NUMBER: _____

FOR OFFICIAL USE ONLY	
DFI Representative:	<input type="text"/>
Confirmation Date:	<input type="text"/>

ATTACHMENT B-1



ERA File Retrieval Information

Please Mail All Completed Forms to:
Anthem Blue Cross and Blue Shield of CO & NV
ATTN: EDI Services CO0111-1134
700 Broadway, Denver, CO 80273
EDI Technical Support: (303) 831-2626, (800) 332-7575
Fax: (303) 764-7057
Incomplete enrollment packages will cause delay.

We must receive a copy of each EOP that displays a unique payee ID number in order to successfully complete ERA and/or EFT requests. Please include these copies with your enrollment form.

Please indicate method of retrieval for your Anthem Blue Cross and Blue Shield of CO & NV Electronic Remittance Advice (ERA) file:

We are a direct submitter and will pick up the ERA files ourselves.
Our submitter ID is _____

Our vendor will retrieve all ERA files for us.

*Vendor Name: _____

*Vendor Contact Name: _____

*Vendor Contact Phone: _____

*Vendor Contact Fax: _____

*Vendor Email: _____

**Please discontinue our current ERA service with vendor: _____*

Please draft a letter on your business letterhead authorizing this third party vendor to retrieve and/or translate your confidential patient and financial information on your behalf. Please indicate in the letter the tax ID(s) the vendor is authorized to retrieve/translate.

Note: If the vendor is new to Anthem Blue Cross and Blue Shield of CO & NV for retrieval of ERA's, your enrollment will be delayed until applicable trading partner agreements are completed.

ATTACHMENT C-1