

## **Payer Agreement Instructions for Tennessee Blue Shield and TennCare - BS032 & MC092**

### **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: Tennessee Blue Shield BS032 TennCare MC092**

**Section 1 – Client Information**

Field	Instructions
Name:	Must match name on file with IRS
Federal Tax ID:	Self explanatory
BCBS of Tennessee Provider ID:	Self explanatory
Riverbend Government Benefits Administrator:	No entry required. Not applicable
National Provider Identifier (NPI)	For multiple providers, please list all NPI(s) in Section 11

**Section 2 – Demographic Information**

Field	Instructions
Physical Location: City, State, Zip	Enter Physical address. Please do not enter a P.O. Box
Office Contact, Fax, Phone, Email:	Self explanatory
Mailing/Correspondence for Electronic Billing:	Complete as indicated.

**Section 3 - Electronic Billing Information.** Pre-filled out, no action needed.

**Section 4 - Payment information.** Fill our according to your payment preference.

**Section 5 – Provider Names and Numbers**

Field	Instructions
For multiple providers list all names and provider numbers here.	
Provider/Facility Name:	Self Explanatory
Individual/Group Number	Number assigned by TN Blue Shield
RGBA Facility Number:	No entry required. Not Applicable
National Provider Identifier	List NPI Identifier if applicable
Tax Identification Number:	Federal Tax ID

Return the Agreement to the Payer:

Tennessee BCBS Fax

(423) 535-7523

Physical address for USPS, FedEx, UPS, etc.

Blue Cross Blue Shield of Tennessee  
Attn.: Provider Network Services – 3TC  
PO Box 180176  
Chattanooga, TN 37402

Once the form(s) have been completed and 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>

<b>Practice Name:</b>	
<b>Practice Tax ID:</b>	

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](http://www.lytec.com/download/Phoenix_Payer_List.pdf) for Lytec users or at [http://www.medisoft.com/download/Phoenix\\_Payer\\_List.pdf](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:
<b>Medicare</b>	Ind #	Ind #	Ind #
	Grp #	Grp #	Grp #
<b>Medicaid</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>BCBS</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>TriCare</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>RR Medicare</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>Other</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>Other</b>	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

## Electronic Billing and EFT Change/Add Request

### Internal Use Only

<b>Internal #:</b>	<b>Provider #1:</b>	<b>Provider #2:</b>	<b>Reason:</b>
<b>Employee Name:</b>		<b>Items Sent:</b>	

### Reason for submitting form

- Adding a Provider to Electronic Billing   
  Changing information on a current Electronic Provider  
 EFT Add/Change   
  Software Request   
  New User

## I. PERSONAL/GROUP/FACILITY INFORMATION

Name: \_\_\_\_\_

Group Practice Name (If requesting group change/add): \_\_\_\_\_

BCBST Provider Number: \_\_\_\_\_ Riverbend Medicare Provider Number: \_\_\_\_\_

NPI Number: \_\_\_\_\_ Tax Identification Number: \_\_\_\_\_ (Required)

## II. ADDRESS INFORMATION

### Physical Address

Address:		City:		State:	Zip:
Phone: ( ) -	Ext:	Fax: ( ) -	After Hours: ( ) -	Ext:	Web site address:
<b>Contact Information:</b>	Name:		Title:		Phone: ( ) -
					Ext:
*E-mail address:					

\*This email address will be used to communicate important information. It is your responsibility to notify BCBST of any changes to the address.

### Electronic Billing Address

Address:		City:		State:	Zip:
Phone: ( ) -	Ext:	Fax: ( ) -	After Hours: ( ) -	Ext:	Web site address:
<b>Contact Information:</b>	Name:		Title:		Phone: ( ) -
					Ext:
*E-mail address:					

### III. ELECTRONIC BILLING INFORMATION

**Will you be submitting any other ANSI transaction and version (e.g., 4010A1)?**

Options Available: 270 Eligibility; 276 Claim Inquiry; 278 Authorization/Referral; 820 Premium Payment; 834 Enrollment/Disenrollment

1.		2.		3.		4.		5.	
<b>Claims Submission</b>									
<b>Who will submit your claims? (select one)</b>		<b>Enter applicable information after selecting which option.</b> (If you are unsure of the Submitter's identification number, verify this information with your vendor before completing.)							
<input type="checkbox"/> Filing Direct with Purchased Software		Software Company Name: _____ Submitter Identification Number: _____ Phone: (    )    -    Ext: _____							
<input type="checkbox"/> Filing Direct with In House Software		<b>List existing mailboxes if associated with a group.</b> (Ex: UBAAA.X12, PTAAA.X12, ECAAA.X12) 1. _____ 2. _____							
<input type="checkbox"/> Filing with third party/billing agent		<b>Please provide information only for the agency that submits the claims to BlueCross BlueShield of Tennessee.</b> Billing Agent / Clearinghouse Name: _____ Billing Contact: _____ Submitter Identification Number: _____ Phone: (    )    -    Ext: _____ Address: _____ City: _____ State: _____ Zip: _____							
<input type="checkbox"/> Filing with free billing software. (i.e.. PC-ACE, Access EDI, etc.)		<b>Please choose which software you will be using:</b> <input type="checkbox"/> <b>PC-ACE</b> <input type="checkbox"/> <b>Access EDI (Web-based claims submission tool)</b> If choosing Access EDI, please indicate the name of your practice management software and complete "Billing Software" section below under Access EDI. _____							
<b>Retrieval of Reports/Remits</b>									
Who will retrieve your Electronic Confirmation?*		<input type="checkbox"/> Provider Office <input type="checkbox"/> Third Party							
Who will retrieve your Electronic Remits?*		<input type="checkbox"/> Provider Office <input type="checkbox"/> Third Party <input type="checkbox"/> Paper Remits							

\*It is your responsibility to obtain and maintain the BlueCross BlueShield of Tennessee Electronic Receipts Confirmation Reports as proof of receipt of claims and for timely filing purposes.

**\*\*A letter of authorization is required if someone other than you will retrieve the ANSI 276/278 or 835 transaction response. Please attach an authorization letter on your letterhead with the entire enrollment packet.**

**Note:** ANSI Format Testing Information, Companion Guides, Edit Listings, Bulletin Board System Information, and the HIPAA Compliancy Self Testing Web Tool can be found on the BlueCross BlueShield of Tennessee Web site at [www.bcbst.com/providers/ecom/](http://www.bcbst.com/providers/ecom/). Please contact the Electronic Business Service Center at (423) 535-5717 or e-mail: [ecom\\_techsupport@bcbst.com](mailto:ecom_techsupport@bcbst.com) for technical support assistance.

**Important:** All responses to ANSI transactions will be delivered electronically to the submitter's EC Gateway BBS mailbox or Access EDI unless otherwise specified. **\*Only HIPAA compliant software can be used. Please view [www.bcbst.com/providers/ecom/](http://www.bcbst.com/providers/ecom/) for listings of approved vendors.**

### Billing Software

**PC-ACE SOFTWARE INFORMATION** (for RGBA Medicare providers only)

<input type="checkbox"/> First time downloading PC-ACE software. ( <a href="http://www.rgbagov.com/Tools/Electronic-Billing-EDI/Downloads.shtml">http://www.rgbagov.com/Tools/Electronic-Billing-EDI/Downloads.shtml</a> ). A profile is required.
<b>(NOTE: Software is not available to Billing Agencies or Clearinghouses)</b>
<input type="checkbox"/> Please send software.
<b>(NOTE: A \$25.00 shipping and handling fee will apply. Please <u>do not send payment</u> with completed profile. Invoice will be mailed.)</b>
<input type="checkbox"/> We are currently using PC-ACE and request the RGBA Medicare provider number listed on Page 2 be added. Please list current PC-ACE file name: _____

### III. ELECTRONIC BILLING INFORMATION (cont'd)

#### Billing Software (cont'd)

##### **ACCESSEDI** (Web Based Claim Filing/Response)

- Claim File Submission ANSI 837 (BCBST Professional Claims Only)  
 The Claims Submission application allows the provider to submit a batch of claims from the providers billing software to the payer using the Web Browser.

##### **3270 EMULATION/DDE ACCESS INFORMATION** (for RGBA Medicare providers only)

- Please send software  
 Please check the operating system of the computer on which the software will be installed:  
 Win 95  Win 98  Win NT  Win 2000  Win ME  Win XP
- Number of software packages requested: \_\_\_\_\_  
**(One (1) software package required per computer @ \$200.00 per package + tax)**  
**(Note: Please do not send payment with completed profile. Invoice will be mailed.)**
- Access to DDE using other connectivity software. Please list the software you will be using:  
 \_\_\_\_\_
- Add additional provider number(s) to existing DDE software.  
 Original Medicare provider number: \_\_\_\_\_ Provider number(s) to be added: \_\_\_\_\_  
 (If additional space is needed, please attach an additional sheet to this document.)

Note: A 3270 License Agreement is required for each package ordered. A CMS EDI Agreement must be on file for each provider. The 3270 License Agreement and the CMS EDI Agreement can be found on the Riverbend Government Benefits Administrator Web site at <http://www.rgbagov.com/Tools/Electronic-Billing-EDI/Forms.shtml>. **Please include with this application.**

Note: Vendors requesting 3270 software or remote system access must have the Medicare Remote Access System Agreement Form completed by their provider. This form can be found at the Riverbend Government Benefits Administrator Web site at <http://www.rgbagov.com/Tools/Electronic-Billing-EDI/Forms.shtml>.

#### User Access

**For RGBA  
 Medicare  
 Providers only**

Please list <b>all individuals</b> who will be accessing BlueCross BlueShield of Tennessee systems. Please indicate the computer systems and transactions each individual will be accessing to ensure that proper security clearance is granted. If more space is needed, please make additional copies of this page.  BlueCross BlueShield of Tennessee must comply with CMS privacy and security regulations and assign individual IDs. It is the responsibility of the client to notify BlueCross BlueShield of Tennessee when an individual listed below leaves the employment of the client or has a legal name change. Failure to do so may result in the agreement being terminated.  <b>*RGBA Medicare users must create a four digit PIN for password resets.</b>			<b>EC Gateway Bulletin Board System</b>	<b>Confirmation Reports</b>	<b>835 Remittance</b>	<b>Access EDI</b>	<b>3270 Dial-Up Connectivity</b>	<b>DDE</b>									
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Individual Names (New Users Only) (First Name, Middle Initial and Last Name)</th> <th style="width: 15%;">Four Digit PIN*</th> <th style="width: 30%;">E-mail Address (Required for Access EDI)</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Individual Names (New Users Only) (First Name, Middle Initial and Last Name)	Four Digit PIN*							E-mail Address (Required for Access EDI)								
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## User Access (cont'd)

List any current User IDs used for accessing the 3270 Emulation Software, Mainframe System (IBM Session Manager) and/or the Companion Data Service (CDS): **Example: ( abc001cc abc001cc AB12345 )**

\_\_\_\_\_

### Modem Access Form Dial-Up User Modem Registry Form

All Dial-Up Users connecting to BlueCross BlueShield of Tennessee (BCBST) for the purpose of sending and receiving files electronically and/or connecting to Riverbend Government Benefits Administration (RGBA) for Direct Data Entry (DDE) access are now required to register their MODEM phone numbers.

**IMPORTANT:** Failure to register your MODEM phone numbers may result in a loss of access. MODEM phone numbers will be used to identify connections to BCBST and RGBA. This will function much like Caller ID.

**PLEASE LIST MODEM PHONE NUMBERS BELOW. For Example: (111) 222-3333**

**Note:** All responses to ANSI transactions will be delivered electronically to the Submitter's EC Gateway BBS or AccessEDI mailbox unless otherwise specified.

**Note:** To revoke an individual's access, please fax a request on the provider's letterhead to (423) 535-7523 noting the name(s) to be removed, the tax ID number and BBS mailbox to which they have access.

## IV. PAYMENT INFORMATION

Make checks payable to:		Payment Details:			
<b>Pay to Name:</b>		<input type="checkbox"/> Roll payments to single check for all providers in the Group <input type="checkbox"/> Payments should be for individual provider			
<b>Pay to Address:</b>					
<input type="checkbox"/> Same as primary <input type="checkbox"/> Other (Please specify)	Address:		City:	State:	Zip:
	Phone: ( ) - Ext:	Fax: ( ) -	After Hours: ( ) - Ext:		
<b>IRS Address:</b>					
<input type="checkbox"/> Same as primary <input type="checkbox"/> Other (Please specify)	Address:		City:	State:	Zip:
	Phone: ( ) - Ext:	Fax: ( ) -	After Hours: ( ) - Ext:		
<b>Electronic Funds Transfer Information* (EFT):</b>					
<input type="checkbox"/> Please check this box if you do NOT wish to receive payment via Electronic Funds Transfer					
<b>Bank Information</b>	Bank Name:		Bank Branch:		
	Address:		City:	State:	Zip:
	Phone: ( ) - Ext:	Fax: ( ) -	After Hours: ( ) - Ext:		
<b>Account Information</b>	Bank Routing Number: (9 digits)		Bank Account Number:		
	<b>Account Type:</b> <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Other: _____				

\*As part of receiving your funds via EFT, you are also agreeing to no longer receive a paper copy of your remittance advice. You can now view/print a copy of your remittance advice by accessing e-Health Services<sup>®</sup> through the BlueAccess link of [www.bcbst.com](http://www.bcbst.com). Electronic Remittance Advices are available without EFT.

**Please attach a copy of a voided check if you elect to receive EFT.**



## ELECTRONIC TRANSMISSION ACKNOWLEDGEMENT

The client sending and receiving data will:

- Maintain adequate security procedures to prevent unauthorized access to data, data transmissions, security access codes, backup files or source documents.
- Maintain complete accurate and unaltered copies of all Source Documents from all Data Transmissions for not less than six (6) years.
- Provide information, documents and other cooperation necessary to assist BlueCross BlueShield of Tennessee in research as it pertains to problem resolution.
- Hold BlueCross BlueShield of Tennessee harmless from any and all claims, actions, damages, liabilities, costs, or expenses, including, without limitation, reasonable attorneys' fees, arising out of any act or omission of performance by provider, provider's employees or business associates.
- Understand it is the provider's responsibility to obtain and maintain the BlueCross BlueShield of Tennessee Electronic Receipts Confirmation Reports as proof of receipt of claims and for timely filing purposes.
- Understand it is the provider and submitter's responsibility to retrieve the BlueCross BlueShield of Tennessee 997 Functional Acknowledgement files and the Electronic Receipts Confirmation Reports and review them for any claims rejections needing to be corrected and resubmitted.
- Understand that any assigned individual User IDs should not be shared, should be used only by that individual, and should not be hard-coded into any system or script. Scripting on the EC Gateway Bulletin Board System is not supported due to potential security violations.

Please sign indicating your acceptance of the Electronic Transmission Acknowledgement.

Name: \_\_\_\_\_  
Please Print Name

Position: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please indicate how you would like to be notified once your request has been processed:

Mail (Mailed to EMC address listed on page 1)

Fax (Faxed to EMC fax number listed on page 1)

Note: It is your responsibility to notify your billing agent or clearinghouse that you are now set up to send and receive electronic transactions.

All information contained in this profile will remain in effect unless otherwise notified.

Please fax to: (423) 535-7523 or mail to: **BlueCross BlueShield of Tennessee**  
**Attn: Provider Network Services**  
**PO Box 180176**  
**Chattanooga, TN 37402**