
Blue Cross Blue Shield Alabama 835

EDI Enrollment Instructions:

- The billing provider must have an EDInsight customer account.
- SAVE this document to your computer.
- OPEN the file in the Adobe Reader program and type directly onto the form.
- COMPLETE the form using the provider's billing/group information as credentialed with payer.
- PRINT, SIGN and SCAN or SAVE the signed form to your PC so that you may submit the form to the EDInsight Enrollment Team using EDInsight Enrollment Manager.
- ERA enrollment processing timeframe is approximately 30 days.
- Support Vendors may contact the EDInsight Enrollment Team to follow up on the ERA setup request or contact the payer directly at EDIEnrollment@bcbsal.org or 205-220-6899.

835 Electronic Remittance Advice:

Complete and submit this form using the billing provider's group information.

1. EDI Enrollment Request for Electronic Remittance (835) Files (1 page)

Complete all applicable fields.

Provider or Authorized Individual must sign where indicated at the bottom of the page.

Submit to EDInsight Enrollment Team:

Within EDInsight - Enrollment Manager:

GO TO or **[ADD Payer Enrollment]** record for this payer.

SELECT record, CLICK **[ATTACH File]** to attach all pages of the completed payer form.

IF prompted, asking if you want to Submit the request, CLICK **[Yes]** -Or- CLICK **[SUBMIT Enrollment]**

ENTER any notes (optional)

CLICK to "**Save and Exit**" notes' window.



**EDI Enrollment Request for
Electronic Remittance (835) Files**

By completing this form, you are enrolling for the receipt of an ERA (835) to be delivered to the Trading Partner ID you are specifying in this enrollment. Completed form should be faxed to EDI Services at 205-733-7362 or emailed to EDIEnrollment@bcbsal.org.

PROVIDER INFORMATION

Provider Name

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	Provider Type Institutional Professional/Dental
National Provider Identifier (NPI)	Trading Partner ID -

PROVIDER CONTACT INFORMATION

Contact Name	Title
Telephone Number	Email Address

ELECTRONIC REMITTANCE ADVICE INFORMATION

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)

Provider Tax Identification Number (TIN):	National Provider Identifier (NPI):
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ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

Clearinghouse Name

Clearinghouse Contact Name	Telephone Number	Email Address
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ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION

Vendor Name

Vendor Contact Name	Telephone Number	Email Address
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SUBMISSION INFORMATION

Reason for Submission

New Enrollment Change Enrollment Cancel Enrollment

Authorized Signature

Represents and warrants that he or she has full power and authority to execute this agreement on behalf of the healthcare 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 (Blue Cross) (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 Blue Cross if the Business Associate changes;

Agrees that Provider will be responsible for all electronic transactions submitted to Blue Cross by Provider, its employees, and its agents;

Agrees that Blue Cross 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 Blue Cross 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.

Written Signature of Person Submitting Enrollment

Printed Name of Person Submitting Enrollment

Submission Date