

BCBS ERA Payer	Enrollment Instructions – ERA
Payer Info	<p>This payer sends confirmation when ERA setup is approved. Yes <input checked="" type="checkbox"/> No</p> <p>Once ERAs begin coming in, this serves as confirmation of the 835 ERA setup.</p> <p>Note: This payer does not guarantee an ERA will be generated for all payments</p>
Checklist of Requirements	<p><input checked="" type="checkbox"/> The billing provider must have a Practice Insight EDI customer account number.</p>
How and Where to Submit this Request	<p>SUBMIT To- Practice Insight</p> <p>LOG INTO EDInsight® GO TO [Search Tools] → [Enrollment] ADD or LOCATE, then SELECT payer enrollment record. CLICK [ATTACH File] to attach completed form to the record. CLICK [SUBMIT Enrollment to PI] to assign to Practice Insight for processing.</p>
Steps / Instructions for completing request.	
Estimated Time of Completion	
Contact Info to Follow Up or Make Inquiries	<p>Contact your EDI support vendor for assistance. Practice Insight Resellers or Support Vendors may contact Practice Insight Enrollment Department to check status of enrollment after 45 days. Please confirm this provider is currently submitting claims to this payer, and has received a payment from this payer within the last 14 days. You may be asked to provide recent payment information which includes, check date, check number and check amount.</p>



Prior to enrolling for ERA, you must be registered with Availity™. Availity, LLC supports the exchange of electronic remittances in the ASC X12 835, version 5010A1 format. The ERA enrollment process establishes an electronic mailbox where Availity will place the electronic remittance file(s) received from payer(s). The provider's Federal Tax ID is required to establish an ERA Receiver mailbox and also will be used to parse remittance transactions from the payer. There is no charge to register with Availity. Visit availity.com for details.

If you are a billing service or clearinghouse requesting to receive the ERA on behalf of a provider, the provider must complete the enrollment documents authorizing you to retrieve their remittance files, or a copy of the Power of Attorney must be submitted with the enrollment form.

This ERA Enrollment Form will be used to activate ERA delivery related to all claims submitted by/on behalf of the enrolling provider, once claims are finalized.

If you have any questions regarding the ERA enrollment process, contact the Blue Cross and Blue Shield of New Mexico (BCBSNM) Electronic Commerce Center at ecommercehotline@bcbsil.com or 800-746-4614. Return your completed, signed form via fax to 312-946-3500.

For commercial claims, the paper Provider Claim Summary (PCS) currently provided by BCBSNM will be discontinued 31 days after your ERA enrollment is processed. For government programs claims, the PCS will continue to be mailed. Additional information, including how to obtain enrollment status, is available on our website at bcbsnm.com/provider.

Complete all fields on pages 1 and 2 of this form. To fill out online, use the tab key to advance from field to field. Once completed, print, sign and fax your form to the BCBSNM Electronic Commerce Center, as noted above.

PROVIDER INFORMATION

Provider Name:				
Provider Address:	Street:	City:	State/Province:	Zip Code/Postal Code:

PROVIDER IDENTIFIERS INFORMATION

Provider Identifiers:										
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):										
National Provider Identifier (NPI): (Billing NPI – must be 10 digits)										

PROVIDER CONTACT INFORMATION

Provider Contact Name:		Title:	
Telephone Number:		Telephone Number Extension:	
Email Address: (Required, if applicable)		Fax Number:	

ELECTRONIC REMITTANCE ADVICE INFORMATION

Preference for Aggregation of Remittance Data: (Select one)	<input type="checkbox"/> Provider Tax Identification Number (TIN)	<input type="checkbox"/> National Provider Identifier (NPI)
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ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

Clearinghouse Name:	
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ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION

Vendor Name:	
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SUBMISSION INFORMATION

Reason for Submission: (Select one)	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Change Enrollment	<input type="checkbox"/> Cancel Enrollment						
Authorized Signature:									
Printed Name of Person Submitting Enrollment:									
Printed Title of Person Submitting Enrollment:									
Submission Date:									

(Please continue to page 2 to complete *Other Data*, including *Receiver/Additional information*.)

OTHER DATA

In addition to the maximum data elements required for ERA enrollment, BCBSNM will need the following information to finalize your request:

RECEIVER INFORMATION

Indicate who will receive the ERA file:

Provider Billing Service Clearinghouse Other *(Please specify):*

Availity Customer ID:

Receiver Name:

Receiver Address:	Street:	City:	State/Province:	Zip Code/Postal Code:

Indicate who will receive the Electronic Payment Summary (EPS) file *(select one)*:

The EPS should go to the ERA Receiver indicated above.
OR
 I need a separate mailbox for my EPS file.*

*Please provide the Availity Customer ID for separate delivery of the EPS:

ADDITIONAL INFORMATION

I would like to receive Blue Plan Secondary Payer ERAs (Medicare Primary) from states other than Illinois, Montana, New Mexico, Oklahoma and Texas.



Multi-Payer Electronic Remittance Advice Enrollment

Rev. 03.04.2014.1

PAYER INFORMATION		Refer to the Availity Health Plan Partner List for payer IDs.	
Payer Name:		Payer ID:	
Payer Name:		Payer ID:	
Payer Name:		Payer ID:	
Payer Name:		Payer ID:	
Payer Name:		Payer ID:	
RECEIVER INFORMATION		* If different than provider contact information.	
Who will receive your ERA files?	Provider	Clearinghouse	Vendor
Receiver Name:		Availity Customer ID:	
Contact Name*:			
Telephone Number*:	Ext:	E-mail Address*:	
PROVIDER INFORMATION		PROVIDER IDENTIFIERS INFORMATION	
Provider Name:	Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):		
Street:			
City:	State/Province:	ZIP Code/Postal Code:	National Provider Identifier (NPI):
Provider Name:	Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):		
Street:			
City:	State/Province:	ZIP Code/Postal Code:	National Provider Identifier (NPI):
PROVIDER CONTACT INFORMATION			
Provider Contact Name:			
Telephone Number:		E-mail Address:	
ELECTRONIC REMITTANCE ADVICE INFORMATION			
Preference for Aggregation of Remittance Data	Provider Tax Identification Number (TIN):		
	National Provider Identifier (NPI):		
SUBMISSION INFORMATION			
Reason for Submission:	New Enrollment	Change Enrollment	Cancel Enrollment
Authorized Signature:			
Important: By typing or signing a name in this field, you acknowledge and agree that you have been authorized by the provider or its agent to initiate, modify, or terminate an enrollment. You further acknowledge and agree that you have the legal authority to perform such action on behalf of your organization. In no event will Availity be liable for any losses or damages including without limitation, indirect or consequential losses or damages, or any loss or damage whatsoever arising from loss of data or profits arising out of, or in connection with this submission.			
Printed Name of Person Submitting Enrollment:		Submission Date:	

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