



## Blue Cross Blue Shield of Alabama

Attention Providers:

To start receiving ERAs electronically from Blue Cross Blue Shield of Alabama, you will need to print and review the enrollment form. Please sign the form and submit to EDS using one of the methods below.

Payer:	Blue Cross Blue Shield of Alabama
Payer ID:	CBAL1
For Enrollment Questions:	Contact the EDS Enrollment Department at (800) 482-3518 or <a href="mailto:Enrollment@edsedi.com">Enrollment@edsedi.com</a>
Payer Enrollment Applications:	<b>EDI Enrollment Request for Electronic Remittance (835) Files</b>
Email or Fax Application to:	<a href="mailto:Enrollment@edsedi.com">Enrollment@edsedi.com</a> Fax (800) 389-9152
Approval Process and Timeframes:	Payer estimates 7-10 business days from date of submission. EDS will deliver ERAs directly to the EDS Portal upon receipt.
Special Instructions:	Paper EOBs will continue until the provider notifies BCBS of Alabama that they no longer wish to receive them. Electronic ERAs are delivered for all claims submitted to BCBS of Alabama whether they are submitted by paper or EDI.

The ERA service enables Blue Cross and Blue Shield of Alabama to provide you with an electronic remittance advice, which is a statement of your claims payments in an electronic format. The form is available online at [www.AlabamaBlue.com](http://www.AlabamaBlue.com) >Provider >For EDI Vendors >EDI Vendor Enrollment Forms.

### **PROVIDER INFORMATION**

**Provider Name** – Complete legal name of institution, corporate entity or practice. For sole proprietors, the individual provider name.

### **PROVIDER IDENTIFIERS INFORMATION**

**Provider Federal Tax Identification Number (TIN)/Employer Identification Number (EIN)** – A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.

**National Provider Identifier (NPI)** – Payee NPI for named provider

**Trading Partner ID** – The provider's submitter ID assigned by the health plan, the provider's clearinghouse or vendor, which consists of an eight-character directory ID and four-character vendor ID. EX: ABCD0001-000A. The remittances will be distributed to the eight-character directory ID.

### **PROVIDER CONTACT INFORMATION**

**Contact Name, Title, Telephone Number and Email Address** – Provide the contact information for the person handling ERA issues for the provider.

### **ELECTRONIC REMITTANCE ADVICE INFORMATION**

**Provider Preference for Grouping Claim Payment Remittance Advice** – Must match preference for electronic funds transfer (EFT) payment. See Provider Identifiers Information.

### **ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION**

**Clearinghouse Name** – Official name of the provider's clearinghouse

**Clearinghouse Contact Name, Telephone Number, Email Address** –

Name, phone number and email address of a contact in clearinghouse office for handling ERA enrollment issues

### **ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION**

**Vendor Name** – Official name of the provider's vendor

**Vendor Contact Name, Telephone Number, Email Address** -

Name, phone number and email address of a contact in vendor's office for handling ERA enrollment issues

### **SUBMISSION INFORMATION**

#### **Reason for Submission**

- **New Enrollment** – Select this option when not already enrolled for ERA (835).
- **Change Enrollment** – Select this option when changing from an existing Trading Partner to a new Trading Partner. Blue Cross allows set-up of ERA (835) for only one Trading Partner ID at a time.
- **Cancel Enrollment** – Select this option when terminating enrollment from the ERA (835) process.

**Authorized Signature** – The written signature and printed name of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment.

**Submission Date** – The date on which the enrollment is submitted.

The form lists the fax number and email address of Blue Cross and Blue Shield of Alabama's EDI Services Department as options for returning the ERA Application form.

**Fax:** 205-733-7362

**Email:** [EDIEnrollment@bcbsal.org](mailto:EDIEnrollment@bcbsal.org)

#### **ERA Enrollment Status**

Contact EDI Services at [EDIEnrollment@bcbsal.org](mailto:EDIEnrollment@bcbsal.org) or 205-220-6899 to inquire about ERA enrollment status.



**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](mailto:EDIEnrollment@bcbsal.org).

**PROVIDER INFORMATION**

Provider Name

**PROVIDER IDENTIFIERS INFORMATION**

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

Grid for TIN/EIN: 9 boxes

Provider Type

Institutional  Professional/Dental

National Provider Identifier (NPI)

Grid for NPI: 10 boxes

Trading Partner ID

Grid for Trading Partner ID: 10 boxes with a dash separator

**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):**

Grid for Provider TIN: 9 boxes

**National Provider Identifier (NPI):**

Grid for National NPI: 10 boxes

**ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION**

Clearinghouse Name

Clearinghouse Contact Name

Telephone Number

Email Address

**ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION**

Vendor Name

Vendor Contact Name

Telephone Number

Email Address

**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**