Payer ID: ALBLU

Alabama
Blue Cross Blue Shield
835

EDI Enrollment Instructions:

- Please 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 this payer.
- Once completed, save for your records, print and **obtain appropriate signature(s).**
- EDI enrollment processing timeframe is approximately **7-10 business days**.
- For assistance with the enrollment form or status, please refer to attached instructions or contact **BCBS at 205-220-6899**.

837 Claim Transactions:

EDI enrollment applies to ERA only and is not necessary prior to sending claims.

835 Electronic Remittance Advice:

EDI Enrollment Request for Electronic Remittance (835) Files

Complete the form as appropriate.

Submit Completed Forms:

Email or Fax to BCBS of Alabama EDI Services

EDIEnrollment@bcbsal.org

205-733-7362

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

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

C R E M E D I 1 – 5 6 4 A

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):

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

Clearinghouse Name

ClaimRemedi

Clearinghouse Contact Name	Telephone Number	Email Address
Enrollment Dept.	866-633-4726	enrollment@claimremedi.com

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION

Vendor Name

ClaimRemedi

Vendor Contact Name	Telephone Number	Email Address
Enrollment Dept.	(866) 633-4726	enrollment@claimremedi.com

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