eSolutions
Strengthen your revenue health

Payer ID: 22099
WS Payer ID: 22099

BCBS - New Jersey, Horizon
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).
- ERA setups are generally completed in approximately **5 business days.**

837 Claim Transactions:

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

835 Electronic Remittance Advice:

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY 835 ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT FORM

Complete all applicable fields.

Check New Enrollment or Change Enrollment under the 'Submission Information' section on Page 2.

The individual completing the form must print date, name, title, and sign where indicated.

Submit Completed Documents:

Email all pages to eSolutions to complete the setup. Do not submit direct to the payer.

ESH@claimremedi.com

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY
835 ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT FORM

To participate in the Horizon BCBSNJ Electronic Remittance Advice (ERA/835) program, please email this completed form to HorizonEDI@HorizonBlue.com or fax this completed form to **1-973-274-4353**.

If you are using a Trading Partner to perform ERA/835, that Trading Partner MUST BE an authorized Horizon BCBSNJ ERA Trading Partner. To obtain a list of authorized Trading Partners, please email a request to HorizonEDI@HorizonBlue.com.

The Horizon BCBSNJ Payer ID is 22099.

PROVIDER INFORMATION

Provider Name: ______________________________

Provider Street Address: ______________________________

City: ______________ State/Province: __________ ZIP Code/Postal: __________

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax ID (TIN) OR Employer ID Number (EIN): ______________________________

National Provider Identifier (NPI): ______________________________

Other Identifier(s) - Assigning Authority (MCARE UPIN Number, Suffix, etc.): ______________________________

PROVIDER CONTACT INFORMATION

Provider Contact Name: ______________________________

Telephone Number: ______________ Telephone Number Extension: __________

Email Address: ______________________________

ELECTRONIC REMITTANCE ADVICE INFORMATION

Preference for Aggregation of Remittance Data (select one from below)

☐ Provider Tax Identification Number (TIN): ______________________________

☐ National Provider Identifier (NPI): ______________________________

Method of Retrieval (*The method by which the provider will receive the ERA from the health plan*)

☐ Download from health plan website

☐ Clearinghouse/Vendor

☐ Other: ______________________________

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ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

Clearinghouse Name: ______________________________

Clearinghouse Contact Name: ______________________________

Clearinghouse Telephone Number: ______________________________

Clearinghouse Email Address: ______________________________

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION

Vendor Name: ______________________________

Vendor Contact Name: ______________________________

Vendor Telephone Number: ______________________________

Vendor Email Address: ______________________________

SUBMISSION INFORMATION

Reason for Submission (select one from below)

☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Authorized Signature (select from below):

Signature of Person Submitting Enrollment: ______________________________

Name of Person Submitting Enrollment: ______________________________

Title of Person Submitting Enrollment: ______________________________

Submission Date: ______________________________