



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms.
12/14/2011 (NF)

Blue Cross Blue Shield – **Capital Blue Cross** Enrollment Instructions and Fax Cover Page **270/271- ELIGIBILITY**

- ✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record added.** Please contact your EDI solutions reseller to confirm your EDI account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck provider numbers to be sure they are valid and accurate. Incorrect provider IDs will cause the enrollment to be delayed or rejected.
- ✓ **Make a copy of the completed enrollment pages.** Note the date and method of submission. Keep a copy of the completed request in case you should need to follow up or resubmit.

FAX FORMS to- Practice Insight, Enrollment Department
713-333-0138

270/271 ELIGIBILITY - Initial Provider Enrollment (New) or (Change of Service)

To register the billing provider group or individual provider to send real time eligibility requests to BS AL, complete these forms:

1. ***FAX Cover Sheet (1 page)***
2. ***Capital Blue Cross Electronic Data Interchange (EDI) Form (1 page)***

Enter data onto the fields that are highlighted.

See fields on top portion to enter the Provider's Name and Provider's NPI #.

See fields on bottom portion to enter- Name, Title, Email, etc of authorized person who is signing from the provider's office.

Authorized Officer or Provider's signature required.

ALLOW 2-4 WEEKS FOR PROCESSING

If it has been over 20 days since request was submitted and you have not yet received confirmation of enrollment, contact EDI support representative or reseller to inquire regarding status of the ERA enrollment. Resellers may contact Practice Insight, Enrollment Department for assistance.

Fax

To: **Practice Insight, LLC**
Attention: Enrollment

From:

Fax: **713.333.0138** Pages: (# of pages including cover)

Phone: Date:

Payer: BCBS – Capital Blue Cross

Please see following page with 270/271 Eligibility Enrollment Request for--

Billing Provider Name: _____

Group NPI #: _____

Name of Your Reseller/Support Vendor:

If there are any questions about this request,

please contact _____ at _____
(your name) (your phone #)



Capital BlueCross

Electronic Data Interchange (EDI) Form

TO: Georganna M. Lerch
Capital BlueCross
PO Box 773631
Harrisburg, PA 17177-3631
Fax (717) 651-4001,
Email Georganna.Lerch@CapBlueCross.com

This is to advise Capital BlueCross and its wholly owned affiliates that _____
(the "Provider") has appointed _____ (the "Agent") as our Agent for the
following purposes:

(Please check all that apply)

- Submission of HIPAA compliant ANSI 837P (Professional claims)
- Submission of HIPAA compliant ANSI 837I (Institutional claims)
- Submission of HIPAA compliant ANSI 270/271 (Eligibility)
- Submission of HIPAA compliant ANSI 276/277 (Claim Status)
- Receive HIPAA compliant ANSI 835 (Electronic Remittance Advice)
- Submission of HIPAA compliant ANSI 278 (Health Services Review)
- Other (Describe) _____

Description of Agency Purposes: _____

List National Provider Identifiers (NPI) Covered by this Agency Agreement: _____

NOTE: Professional Providers: please provide Type 2 – Organization NPI(s), not Type 1 – Individual NPI(s)

Capital BlueCross is authorized to treat the Agent as though it is the Provider for the purposes noted above.

The Provider understands that Capital BlueCross will be relying on this representation for claims processing purposes and for purposes of releasing confidential information. Provider confirms that the Agent has signed a written agreement pursuant to which it has agreed to preserve any information which it receives from Capital BlueCross as confidential, and in accordance with all applicable laws and regulations.

Further, in consideration of Capital BlueCross' acceptance of the Agent, the Provider agrees that it will indemnify and hold Capital BlueCross harmless for any and all damages, claims and expenses that Capital BlueCross may incur or that may be asserted against Capital BlueCross as a result of the negligent or intentional actions of the Agent in carrying out its duties in connection with the purposes noted above.

Capital BlueCross shall be entitled to rely on this letter until revoked in writing.

Provider understands that Capital BlueCross reserves the right to modify its policies relating to the release of confidential information, including the release of subscriber information to providers or their Agents, at any time.

SIGNATURE _____ PRINT NAME _____

(Must be an Officer of the Provider)

TITLE _____ TELEPHONE _____

DATE _____ FAX NUMBER _____

EMAIL _____

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company® and Keystone Health Plan® Central. Independent licensees of the Blue Cross and Blue Shield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.