



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms
3/24/11 (FE,IE)

Blue Shield Massachusetts (00200) Enrollment Instructions – Professional Claims and ERA

- ✓ **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. Invalid or 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 COMPLETED FORMS TO-
Practice Insight, Enrollment Department
713-333-0138

837 - Initial Provider Enrollment and Re-Enrollment (Change of Service)

To authorize Practice Insight to submit claims on behalf of a BILLING PROVIDER, the provider must complete the following sections:

1. EDI Trading Partner Enrollment Form (1 page form)
Fill out requested information in section, "Provider Information."

835 - Electronic Remittance Request (New) or (Change of Service)

To authorize Practice Insight to retrieve 835 ERA files, the provider must complete the following sections:

1. In addition to the claims enrollment step above, you must mark the box in the column for "835." This indicates you wish to have your ERA files delivered to Practice Insight.

ALLOW 2-4 WEEKS FOR PROCESSING

If it has been over 30 days since request was submitted, and you have not yet received confirmation of enrollment, contact your reseller for assistance.

*To contact this payer, please email: EDIsupport@bcbsma.com
and type "Enrollment Question" in the subject line.*



MASSACHUSETTS

EDI Trading Partner Enrollment Form

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

SUBMITTER REQUEST

Type of request	New <input type="checkbox"/>	Update <input type="checkbox"/>	Cancel <input type="checkbox"/>	Cancel Date
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GENERAL/DEMOGRAPHIC INFORMATION

Date of Request	Submitter ID (assigned by BCBSMA)		
Submitter Name			
Address 1			
Address 2			
City	State	Zip Code	
Please indicate if you are a Billing Service or Clearinghouse		Billing Service <input type="checkbox"/>	Clearinghouse <input checked="" type="checkbox"/>

SYSTEM/SOFTWARE

Practice Management System/Software products (if applicable)	NA
Please indicate if you use NEHEN to submit claims/receive remittances	
Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

CONTACT INFORMATION

Primary Contact Name	Title
Telephone #	Fax #
Email Address	
Technical Contact Name	Title
Telephone #	Fax #
Email Address	

TRANSACTIONS (Version 4010A1)

① INDIVIDUAL FORMS MUST BE COMPLETED FOR EACH CLAIM TYPE REQUESTED.

Transaction Type	837I <input type="checkbox"/>	837P <input checked="" type="checkbox"/>	837D <input type="checkbox"/>	835 <input checked="" type="checkbox"/>
Proposed Test Date				
Target Production Date				

PROVIDER INFORMATION

① REQUIRED. Please include all Billing Providers below for which you intend to submit claims transactions.
 ① Additional Providers can be entered on Page 2 of this form.

Provider Name	National Provider Identifier	Federal Tax Identifier	835
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>

Questions? Send an email to EDISupport@bcbsma.com with "Enrollment Questions" in the Subject line.

- Instructions:
- Complete this form
 - Email to: EDISupport@bcbsma.com
 - Indicate "Enrollment Form" and your Submitter ID in the Subject line
 - The EDI Support Team will contact you within 2 business days