



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms  
02/16/2012 (IE)

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**Blue Cross Blue Shield - NEVADA  
Anthem WEST  
Enrollment Instructions – Professional ERA**

- ✓ **BEFORE enrolling**, you MUST have a Practice Insight EDI customer account # with billing provider record added. 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 enrollment delays.
- ✓ **Keep a copy of the completed enrollment pages.** Note the date and method of submission and file away a copy of the paperwork, in case you should need to resubmit or follow up on the enrollment request.

**FAX COMPLETED FORMS TO-  
ANTHEM BCBS, EDI SOLUTIONS  
303-764-7057**

**837- CLAIMS Provider Enrollment (New) or (Change of Service)**

No Enrollment necessary

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

If the provider wishes to authorize Practice Insight to retrieve 835 ERA files, the provider must complete this form:

**1. ANTHEM – ERA Enrollment Form (1 page)**

Complete top portion of the form with your Billing Group Provider Information.

If provider is currently receiving ERAs via another clearinghouse and wants to switch to Practice Insight Put ✓ next to We are switching vendors and be sure to include current clearinghouse and/or vendor

If provider has never received ERAs, Put ✓ next to Our vendor will retrieve all ERA files for us.

See bottom – Signature Required

**NOTE:** EFT Enrollment form (1 page) EFT is optional. This form is provided for convenience only.

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**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 or software support vendor for assistance or call BCBS edi dept. at 1-800-332-7575.*



# ERA Enrollment Form

Please Fax or E-mail Completed Forms to:  
Fax: (888) 438-7965  
edianthemwest.support@anthem.com  
**Anthem Blue Cross and Blue Shield**  
ATTN: EDI Solutions C00109-0934  
700 Broadway, Denver, CO 80273  
EDI Technical Support: (800) 332-7575  
**Incomplete or illegible enrollment packages will be returned unprocessed.**

Please print clearly. A separate form is required for each Tax Identification Number.

Institutional  Professional  Dental

Provider Name: \_\_\_\_\_ Location code \_\_\_\_\_  
Tax ID #: \_\_\_\_\_ NPI #: \_\_\_\_\_ Medicare #: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Please indicate method of retrieval for your Anthem Blue Cross and Blue Shield Electronic Remittance Advice (ERA) file:

- We are a direct claim submitter and will download our own ERA files.  
Our electronic mailbox ID is (ex: CO12345P) \_\_\_\_\_  
Our ERA translation software is \_\_\_\_\_
- Please assign a new mailbox to download our own ERA files.  
Our ERA translation software is \_\_\_\_\_
- We are switching vendors. Please discontinue our current ERA services with vendor: \_\_\_\_\_
- Our vendor will retrieve all ERA files for us. (Please have vendor complete the following fields.)  
Vendor Name: \_\_\_\_\_  
Vendor Contact Name: \_\_\_\_\_  
Vendor Contact Phone: \_\_\_\_\_  
Vendor Email: \_\_\_\_\_  
Vendor Submitter ID: \_\_\_\_\_

Note: Please be sure your vendor is set up to receive ERA files from Anthem Blue Cross Blue Shield. We cannot process this request if they are not set up.

**A Company Officer must sign this form. This is a legal document.**

PRINT NAME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
TITLE: \_\_\_\_\_ DATE: \_\_\_\_\_ PHONE: \_\_\_\_\_



# EFT Enrollment Form

Please Fax or E-mail Completed Forms to:  
 Fax: (888) 438-7965  
 edianthemwest.support@anthem.com  
**Anthem Blue Cross and Blue Shield**  
 ATTN: EDI Solutions C00109-0934  
 700 Broadway, Denver, CO 80273  
 EDI Technical Support: (800) 332-7575  
**Incomplete or illegible enrollment packages will be returned unprocessed**

Anthem Blue Cross and Blue Shield is hereby authorized to deposit payments for claims to the account listed below.  
**A voided blank check or bank authorization letter is required for the account receiving the direct deposit.**  
**DEPOSIT SLIPS ARE NOT ACCEPTED UNDER ANY CIRCUMSTANCES.**

<b>PROVIDER NAME (REQUIRED)</b>		<b>MEDICARE PROVIDER NUMBER</b> <small>(Required for Institutional only)</small>	
E-mail:			
<b>ADMINISTRATIVE CONTACT:</b> <small>(REQUIRED)</small>		<b>TAX ID NUMBER:</b> <small>(REQUIRED)</small> <small>(REQUIRED)</small>	
<b>TITLE:</b> <small>(REQUIRED)</small>		<b>PHONE NUMBER:</b> <small>(REQUIRED)</small>	

### BANK INFORMATION Bank Account Change Only

<b>NAME ON BANK ACCOUNT (REQUIRED)</b>	
<b>ACCOUNT TYPE (REQUIRED)</b> <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS	
<b>BANK NAME (REQUIRED)</b>	<b>BRANCH NAME (REQUIRED)</b>
<b>COMPLETE BANK ADDRESS (REQUIRED)</b>	<b>BANK PHONE NUMBER (REQUIRED)</b>
<b>ACCOUNT NUMBER (REQUIRED)</b> <small>Must match letter or voided Check</small>	<b>TRANSIT/ABA NUMBER (REQUIRED)</b> <small>Must match letter or voided Check</small>

**You are authorizing Anthem Blue Cross Blue Shield to deposit payments for claims to the account listed above.  
 This is a legal document. An authorized signer on the bank account must sign this form.**

<b>PRINT NAME:</b> <small>(REQUIRED)</small>	_____	<b>SIGNATURE:</b> <small>(REQUIRED)</small>	_____
<b>TITLE:</b> <small>(REQUIRED)</small>	_____	<b>PHONE NUMBER:</b> <small>(REQUIRED)</small>	_____
<b>DATE SIGNED:</b> <small>(REQUIRED)</small>	_____	<b>FAX NUMBER:</b>	_____

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**ATTACHMENT B**