



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms  
7/25/2011 (IE, NE)  
<http://www.ask-edi.com/forms.htm>

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**Blue Cross Blue Shield – North East New York (BS800),  
HealthNow New York (55204), Western New York (BS801)  
ASK, Inc.**

**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.
- ✓ **Keep 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-**  
ASK EDI Department, 785-290-0720

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

If the provider has NOT submitted claims electronically to this payer or if the provider HAS SUBMITTED electronic claims to this payer VIA ANOTHER CLEARINGHOUSE, and they now want to submit via Practice Insight, the provider must complete this form:

1. EDI Change of Information Form (3 pages)

Section 3 - See New York Customers; Enter Billing NPI and Billing Provider Name.

**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. EDI Enrollment Form- Application for Electronic Remits (835) Enrollment (3 pages)

Section 6 - Enter Billing Provider Information.

Put a ✓ in box to *Select Payer(s)*, e.g, BCBSKWN, BSNENY, and/or HNNY

Section 7 - Enter Billing Provider Information.

Section 8 – Provider or Provider's Representative Signature Required.

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**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 edi enrollment, contact ASK EDI at 800-472-6481 or send email inquiry to [askedi@ask-edi.com](mailto:askedi@ask-edi.com)*

# EDI Change of Information Form



**This form is to be used to:**

- a) change trading partner or vendor information,  
**OR**
- b) add additional NPI or transaction

**To change trading partner contact information:**

- e-mail new contact information to askedi@ask-edi.com (only if e-mail address contains name of facility)  
**OR**
- fax new contact information on company letterhead to 785-290-0720.

## Trading Partner Information

Trading Partner Number: \_\_\_\_\_

Organization Name (legal name): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_  
Area Code

Fax #: \_\_\_\_\_  
Area Code

E-mail Address: \_\_\_\_\_

Section 1

## Vendor Information

Software Company Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Telephone #: \_\_\_\_\_  
Area Code

Fax #: \_\_\_\_\_  
Area Code

E-mail Address: \_\_\_\_\_

Section 2

**NPI and Transactions**

Select the appropriate transaction for the Organizational (Billing) NPI you are enrolling.

Section 3

| <b>Payers</b>   | <b>Billing NPI Number(s)</b> | <b>Name of Billing Provider</b> |
|---|------------------------------|---------------------------------|
| <b>Blue Cross Blue Shield of Kansas (BCBSKS):</b><br><input type="checkbox"/> 837P (professional claims)<br><input type="checkbox"/> 837I (institutional claims)<br><input type="checkbox"/> 837D (dental claims)<br><input type="checkbox"/> 270/271 (eligibility inquiry/benefits)<br><input type="checkbox"/> 276/277 (claims status)                                    |                              |                                 |
|   |                              |                                 |
|   |                              |                                 |
|   |                              |                                 |
|   |                              |                                 |
|   |                              |                                 |
| <b>Blue Cross Blue Shield of Kansas City (BCBSKC):</b><br><input type="checkbox"/> 837P (professional claims)<br><input type="checkbox"/> 837I (institutional claims)<br><input type="checkbox"/> 837D (dental claims)  |                              |                                 |
|   |                              |                                 |
|   |                              |                                 |
|   |                              |                                 |
|   |                              |                                 |
|   |                              |                                 |
| <b>New York Customers</b><br>(Those submitting for <b>HealthNow New York (HNNY)</b> or <b>Blue Cross Blue Shield of Western New York (BCBSWNY)</b> or <b>Blue Shield of Northeastern New York (BSNENY):</b><br><input type="checkbox"/> 837P (professional claims)<br><input type="checkbox"/> 837I (institutional claims)<br><input type="checkbox"/> 837D (dental claims) |                              |                                 |
|   |                              |                                 |
|   |                              |                                 |
|   |                              |                                 |
|   |                              |                                 |
|   |                              |                                 |
| <b>Preferred Health Professionals (PHP):</b><br><input type="checkbox"/> 837P (professional claims)<br><input type="checkbox"/> 837I (institutional claims)   |                              |                                 |
|   |                              |                                 |
|   |                              |                                 |
| <b>EDI Midwest Electronic Clearinghouse</b><br>(Requires Contract)<br><input type="checkbox"/> 837P (professional claims)<br><input type="checkbox"/> 837I (institutional claims)   |                              |                                 |
|   |                              |                                 |
|   |                              |                                 |
|   |                              |                                 |
| <b>TAX ID:</b> Required for EDI Midwest   |                              |                                 |

## **General Information**

**Please provide in writing to ASK any future changes to the information contained in this EDI setup form within 5 business days of the change.**

**ASK will make every attempt to give 60 days notice of any material changes to the EDI system that may effect trading partner data transmissions. Updates to any system changes will be made through e-mail list notification on the ASK Web site. Trading partners are responsible for signing up for the e-mail list notifications.**

**In an effort to keep our records up to date, provider numbers with no activity for at least six months will be removed from a trading partner number. Once removed from a trading partner number, the EDI enrollment form will need to be completed to re-add this number.**

**Kansas law applies to this business relationship.**

Completed EDI enrollment forms may be **faxed to:** 785-290-0720

**emailed to:** askedi@ask-edi.com

**Mailed to:** ASK  
P.O. Box 3500  
Topeka, KS. 66601-3500

**\*\*\*All pages must be returned\*\*\***

\* Administrative Services of Kansas (ASK) is Blue Cross and Blue Shield of Kansas DBA ASK.

# EDI Enrollment Form

Application for Electronic Remits (835) Enrollment



Section 1

### Request Type

- New enrollment (request for a new trading partner number)
- Existing trading partner adding additional Billing NPI provider numbers

Section 2

### Trading Partner Information

Trading Partner Number: (for existing trading partner) \_\_\_\_\_

Organization Name (legal name): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Name 1: \_\_\_\_\_

Contact Name 2: \_\_\_\_\_

Telephone #: \_\_\_\_\_  
Area Code

Fax #: \_\_\_\_\_  
Area Code

E-mail Address: \_\_\_\_\_

Section 3

### Type of Organization (new trading partner enrollment only):

- Clearinghouse
- Billing Service

(Leave blank if neither description applies)

Section 4

### Vendor Information (new trading partner enrollment only)

Software Company Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Telephone #: \_\_\_\_\_  
Area Code

Fax #: \_\_\_\_\_  
Area Code

E-mail Address: \_\_\_\_\_

**Communication Type (new trading partner enrollment only)**

- Internet
- Secure FTP
- Network Service Vendor (i.e.: IVANS or Vision Share)

**NPI**

| 12 Digit Payee Number<br>(New York Customers Only) | Billing NPI Number(s) | Name of Billing Provider |
|--|-----------------------|--------------------------|
|  |                       |                          |
|  |                       |                          |
|  |                       |                          |
|  |                       |                          |
|  |                       |                          |

**Select Payer you will be receiving remittance from.**

- Blue Cross and Blue Shield of Kansas (BCBSKS)
- Blue Cross and Blue Shield of Kansas City (BCBSKC)
- Blue Cross and Blue Shield of Western New York (BCBSWNY)
- Blue Shield Northeastern New York (BSNENY)
- HealthNow New York (HNNY)

**Note:**

- Billing NPI, can only be loaded under one trading partner number for the 835 (electronic remittance).
- Setup will be completed within 3-5 business days of receipt.
- If interested in submitting 837(claims) complete EDI Enrollment Form for 837, or the EDI change form, if you are an existing trading partner.

**Provider Information**

Provider will be notified of 835 enrollment(s). Please submit provider information below if different than trading partner information:

Provider/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Attention/Contact Name: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Signatures**

A signature is required from either the provider or an authorized provider representative. Only one billing provider may be enrolled per form.

**\*\*Signing this agreement will override any previous 835 enrollments for the indicated NPI numbers.**

**Provider  
or  
Provider's Representative:**

\_\_\_\_\_  
(Sign)

\_\_\_\_\_  
(Print)

\_\_\_\_\_  
(Print Title) (Date)

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**emailed to:** [askedi@ask-edi.com](mailto:askedi@ask-edi.com)  
**Mailed to:** ASK  
P.O. Box 3500  
Topeka, KS. 66601-3500

**\*\*\*All pages of EDI Enrollment form must be returned\*\*\***

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