BCBS or Blue Choice HMO - SOUTH CAROLINA
Enrollment Instructions – Professional Claims & 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.

MAIL 837 REQUEST (BCBS EDI Trading Partner Enrollment) TO-
Blue Cross Blue Shield South Carolina
Technology Support Center EDI Enrollment, AA-E05
I-20 at Alpine Road
Columbia, SC 29219

MAIL 835 REQUEST (Addendum to ERA Enrollment For...) TO-
Blue Cross Blue Shield of South Carolina
2300 Springdale Drive
Attn: AG-280
Camden, SC 29020-1728

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

If the provider has NOT submitted claims electronically to this payer, or wants to make a change to Practice Insight for electronic claims, the provider must complete this form:

1. BCBS EDIG Trading Partner Enrollment Form ASC X12N Transactions (2 pages)
   Page 4- Put check to right of ASC X12N835 (only if you want 835 ERAs).
   Enter Billing Provider Name, Tax ID and State under "Customer's Information"

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

If the provider wishes to authorize Practice Insight to retrieve 835 ERAs, the provider must- :

1. BCBS EDIG Trading Partner Enrollment.. (See instructions above for this form.)
2. ADDENDUM TO ERA ENROLLMENT FORM (2 pages)
   Page 1- ENTER the Billing Provider's information. SEE right column to add name, title, signature, phone no and email address of authorized person from provider's office.
   SEE also, "**Remit Setup Date**" to enter effective date for when provider wants to begin receiving electronic remits via Practice Insight.
   Page 2- Only needed, if there are additional locations for the Billing Provider.

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 SC EDIG Operations at 1-800-868-2505.

BlueCross EDIG Trading Partner Enrollment Form
ASC X12N Transactions

Date: ______________________

Action Requested: (Check One)
- ☐ New Trading Partner ID
- ☑ Change
- ☐ Cancel

Trading Partner Name: Practice Insight, LLC

Trading Partner ID: CGW0290TX6

Federal Tax ID #: 161622439

Type of Business: (Check One)
- ☐ Institutional Health Care Provider
- ☑ Clearinghouse
- ☐ Billing Service
- ☑ Professional Health Care Provider
- ☐ Health Care Plan
- ☐ Retail Pharmacy
- ☐ Pharmacy Benefit Manager
- ☐ Software Vendor
- ☐ Other *(indicate)*: ______________

Line of business: (Check One)
- ☑ BlueCross BlueShield of South Carolina Commercial
- ☐ TRICARE

Start Date: ______________ (mm/dd/ccyy) **End Date:** ______________ (mm/dd/ccyy)
(Required when canceling an account)

Compression: (Check One)
- ☑ No Compression
- ☐ PKZIP
- ☐ UNIX

Protocol: (Check One)
- ☐ NDM
- ☐ FTP DIALUP
- ☐ ASYNC DIALUP (product)__________
- ☑ Secure FTP
- ☐ VPN
- ☐ LU6.2 __________
- ☐ TCPIP
- ☐ Other *(indicate)*: __________

Service Address

Address 1: 1 Greenway Plaza, Suite 350

Address 2:

City/State/ZIP: Houston, TX 77046

Billing Address (If different from the Service Address)

Address 1: NA

Address 2:

City/State/ZIP: ______________

Primary Contact Information

First / Last Name: Enrollment Dept at Practice Insight **E-mail:** enrollment@practiceinsight.net

Telephone: (713) 333-6000 ext. 1 **Fax:** (713) 333-0138

Primary Technical Contact Information

First / Last Name: Support Dept at Practice Insight **E-mail:** support@practiceinsight.net

Telephone: (713) 333-6000 ext. 1 **Fax:** (713) 333-6006

After Hours Technical Contact Information

First / Last Name: ______________ **E-mail:** ______________

Telephone: ( ) ___-____ ext.____ **Fax:** ( ) ___-____

On Call Technical Contact Information

First / Last Name: ______________ **E-mail:** ______________

Telephone: ( ) ___-____ ext.____ **Fax:** ( ) ___-____

Transaction Volume Estimates

Transmission*	Y/N**	Avg. Trans†	Transmission*	Y/N**	Avg. Trans†
ASC X12N 820 (004010X061A1)	☐	/wk	ASC X12N 835 (004010X091A1)	☑	/wk
ASC X12N 270 (004010X092A1)	☐	/wk	ASC X12N 837I (004010X096A1)	☐	/wk
ASC X12N 271 (004010X092A1)	☐	/wk	ASC X12N 837P(004010X098A1)	☑	/wk
ASC X12N 276 (004010X093A1)	☐	/wk	ASC X12N 837D (004010X097A1)	☐	/wk
ASC X12N 277 (004010X093A1)	☐	/wk	ASC X12N 837COB I (004010X096A1)	☐	/wk
ASC X12N 278 (004010X094A1)	☐	/wk	ASC X12N 837COB P (004010X098A1)	☐	/wk
ASC X12N 834 (004010X095A1)	☐	/wk	ASC X12N 837COB D (004010X097A1)	☐	/wk

* Versions supported as of 10/16/2003 † Average number of transactions per week ** Yes / No

If a vendor's software is used to create ASC X12N transactions submitted to the EDI Gateway, please provide the vendor's name and address below, and list the transactions.

Vendor's Information

Vendor's Name: N A

Address 1:

Address 2:

City/State/ZIP:

Transactions:

Customer's Information

If your business is authorized to send or receive transactions in behalf of another entity, please provide the entity's name, federal tax identification number and service/physical address state. **This is required for all transactions.**

Name	Federal Tax Identification Number	State	Add/Change/Remove (A/C/R)
			ADD
			ADD
			ADD
			ADD
			ADD
			ADD
			ADD
			ADD
			ADD
			ADD
			ADD
			ADD
			ADD
			ADD
			ADD
			ADD
			ADD
			ADD

ADDENDUM TO ERA ENROLLMENT FORM
FOR BILLING SERVICES AND CLEARINGHOUSES
BLUECROSS BLUESHIELD OF SC

2300 Springdale Drive Attn: AG-280 Camden, SC 29020-1728

I hereby authorize **Practice Insight, LLC** to receive Electronic
BILLING SERVICE / CLEARINGHOUSE
Remittances Advices (ERA's) on my behalf. I understand that ERA's contain payment information concerning my processed BCBSSC and all BCBSSC intermediaries claims. I am authorized to endorse this addendum on my behalf of my company, and I acknowledge that it is my responsibility to notify BCBSSC in writing if I wish to revoke this authorization.

BCBSSC BILLING TAX ID NUMBER		TRADING PARTNER / SUBMITTER ID NUMBER **CGW0290TX6 / 161622439**
NATIONAL PROVIDER IDENTIFIER (NPI #)		NAME / TITLE (PLEASE PRINT)
CORPORATE / HEADQUARTERS NAME		SIGNATURE
ADDRESS		REMIT SETUP DATE
CITY/ STATE / ZIP		PHONE NUMBER
		EMAIL ADDRESS

Fill out this page if there are satellite offices that will be receiving ERA's as well:

BCBSSC PROVIDER TAX ID#	NATIONAL PROVIDER IDENTIFIER #	BUSINESS NAME AND LOCATION