# Electronic Data Interchange (EDI) Enrollment for ANSI 835 Electronic Remittance Advice Instructions

**Provider Name** – Required - Complete legal name of institution, corporate entity, practice or individual provider.

**Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)** – Required - A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.

**National Provider Identifier (NPI)** – Required when provider has been enumerated with an NPI - A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions -.
Note: Professional Providers: please provide Type 2 – Organization NPI(s), not Type 1 – Individual NPI(s)

**Provider Taxonomy Code**- Optional – complete if selected/assigned - A unique alphanumeric code, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification and Area of Specialization.

**Provider Contact Name** – Required - Name of a contact in provider office for handling ERA issues.

**Provider Contact Telephone Number** – Required - Contact's telephone number

**Provider Contact email address** – Required if contact has an email address - An electronic mail address at which the health plan might contact the provider.

**Provider Contact Fax Number** – Optional - A number at which the provider can be sent facsimiles.

**Electronic Remittance Advice Information - Preference for Aggregation of Remittance Data**

Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFT payment; select:

Provider Tax Identification Number (TIN) or National Provider Identifier (NPI)

**Method of Retrieval** -Optional (Required if the provider is not using an intermediary clearinghouse or vendor) The method in which the provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.).

Direct FTP connection with Capital BlueCross, Web File Transfer with Capital BlueCross, Clearinghouse or Vendor

## Electronic Remittance Advice Clearinghouse Information - Please complete if a clearinghouse is being used

**Clearinghouse Name Name** - Official name of the provider's clearinghouse
**Clearinghouse Contact Name** -Name of a contact in clearinghouse office for handling ERA issues
**Telephone Number** - Telephone number of contact
**Email Address** - An electronic mail address at which the health plan might contact the provider's clearinghouse

## Electronic Remittance Advice Vendor Information - Please complete if a vendor is being used.

**Vendor Name** - Official name of the provider's vendor
**Vendor Contact Name** -
**Vendor Telephone Number** - Telephone number of contact
**Vendor Email Address** - An electronic mail address at which the health plan might contact the provider's vendor

**Reason for Submission:** Select the type of enrollment being requested:

New Enrollment - Select New Enrollment if you are currently not receiving the ANSI 835 ERA and would like to begin.
Change Enrollment – Select Change Enrollment if you are currently receiving the ANSI 835 ERA through one venue and would like to change to another, i.e.: Changing clearinghouses or connectivity methods.

Cancel Enrollment – Select Cancel Enrollment if you are currently receiving the ANSI 835 ERA and wish to discontinue and return to a paper Statement of Remittance.

**Authorized Signature – Required - select from below:** The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment.

> **Electronic Signature of Person Submitting Enrollment -**
> **Written Signature of Person Submitting Enrollment** - A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity
> **Printed Name of Person Submitting Enrollment** - The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment
> **Printed Title of Person Submitting Enrollment** - The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment.

**Submission Date** – (CCYYMMDD format) the date on which the enrollment is submitted – This will be system generated.

**Requested ERA Effective Date** - (CCYYMMDD format) the Date the provider wishes to begin ERA; per Phase III CORE Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0: there may be a dual delivery period depending on whether the entity has such an agreement with its trading partner

## Additional Services:

If you would like to also enroll for other EDI transactions - 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)
- ☐ Submission of HIPAA compliant ANSI 278 (Heath Services Review)
- ☐ Other (Describe) ______________________________________

Completed forms may be emailed to Provider.Automation@capbluecross.com or printed and faxed to Provider Automation at 717-651-4001 or mailed to

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