



## EFT ENROLLMENT PROCESS TO SUPPORT HEALTH CARE CLAIM PAYMENTS

Capital BlueCross is offering Electronic Funds Transfer (EFT) through an automated Clearing House System for claim payment(s) for services rendered to Capital BlueCross subscribers/members; by completing this document the Provider is authorizing Capital BlueCross to make payments by EFT, and directs that all such EFT transfers be made as provided below:

### Provider Information:

Provider Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip Code/Postal Code \_\_\_\_\_

### Provider Identifiers Information:

#### Provider Identifiers:

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) \_\_\_\_\_

National Provider Identifier (NPI) \_\_\_\_\_

### Provider Contact Information:

Provider Contact Name \_\_\_\_\_

Telephone Number \_\_\_\_\_ Email Address \_\_\_\_\_

### Financial Institution Information:

Financial Institution Name \_\_\_\_\_

Financial Institution Routing Number \_\_\_\_\_

Type of Account at Financial Institution  Checking  Savings

Provider's Account Number with Financial Institution \_\_\_\_\_

Account Number Linkage to Provider Identifier  Provider Tax Identification Number (TIN) \_\_\_\_\_

National Provider Identification Number (NPI) \_\_\_\_\_

Reason for Submission:  New Enrollment  Change Enrollment  Cancel Enrollment

### Authorized Signature:

Written Signature of Person Submitting Enrollment \_\_\_\_\_

Printed Name of Person Submitting Enrollment \_\_\_\_\_

Printed Title of Person Submitting Enrollment \_\_\_\_\_

Submission Date \_\_\_\_\_ Requested EFT Start/Change/Cancel Date \_\_\_\_\_

**Provider agrees to submit a new EFT authorization Form and give a thirty (30) day prior written notice to Capital BlueCross of any changes in its depository information, ABA number, other payment instructions, or any changes in information on this form (such as a new provider contact person, etc.).**

Return form to: General Accounting  
Capital BlueCross  
Harrisburg, PA 17177-3233

Fax: 717.651.8044  
Email: [cbc.genacctunit-cashdisb@capbluecross.com](mailto:cbc.genacctunit-cashdisb@capbluecross.com)

**The email will need to be sent through SecureMail.  
Please refer to the attached instructions for procedures.**

If you have specific questions on this form, please email [cbc.genacctunit-cashdisb@capbluecross.com](mailto:cbc.genacctunit-cashdisb@capbluecross.com).

To obtain the status of your EFT enrollment, please refer to the instructions provided via [capbluecross.com](http://capbluecross.com).

**NOTE: If your organization has multiple NPI Numbers, a separate form must be completed and submitted for each practice/group. The person(s) properly authorized by the organization must sign the Authorization Form.**

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

## EFT ENROLLMENT PROCESS TO SUPPORT HEALTH CARE CLAIM PAYMENTS

### ***Instructions for completing the EFT Enrollment Form***

Please type or print legibly.

Use only black or blue ink to complete paper form.

Online form can be accessed at [capbluecross.com](http://capbluecross.com):

- Select *for health professionals*
- Select *General Resources* (on the left)
- Select *Electronic Funds Transfer* (on the left)

Please allow four weeks for enrollment process, which includes pre-note verification. If after four weeks you do not start receiving EFT payments, you may email [cbc.genacctunit-cashdisb@capbluecross.com](mailto:cbc.genacctunit-cashdisb@capbluecross.com).

### ***Provider Information – Please fill out completely***

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

#### **Provider Address**

**Street** – The number and street name where a person or the organization can be found.

**City** – City associated with provider address field.

**State/Province** – ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable County.

**Zip Code/Postal Code** – System of postal-zone codes (zip stands for “zone improvement plan”) introduced in the U.S in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.

### ***Provider Identifiers***

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

**National Provider Identifier (NPI)** – A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care 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 health care 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. Please provide the Organizational NPI number.

### ***Provider Contact Information***

**Provider Contact Name** – Name of a contact in provider office for handling EFT issues

**Telephone Number** – Associated with contact person

**Email Address** – An electronic mail address at which the health plan might contact the provider

### ***Financial Institution Information***

**Financial Institution Name** – Official name of the provider’s financial institution.

**Financial Institution Routing Number** – A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited. This is also called an ABA number.

**Type of Account at Financial Institution** – The type of account the provider will use to receive EFT payments, e.g. Checking, Savings.

**Provider’s Account Number with Financial Institution** – Provider’s account number at the financial institution to which EFT payments are to be deposited.

**Account Number Linkage to Provider Identifier** – Provider preference for grouping (bulking) claims payments; must match preference for v5010x12 835 remittance advice.

Must fill out one of the two options below:

**Providers Tax Identification Number (TIN)**

**National Provider Identifier (NPI)**

**Reason for Submission – Must select one from below:**

**New Enrollment**  
**Change Enrollment**  
**Cancel Enrollment**

**Authorized Signature** – 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.

**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** – The date on which the enrollment is submitted.

**Requested EFT Start/Change/Cancel Date** – The date on which the requested action is to begin.

**For questions about this form, please email:** [cbc.genacctunit-cashdisb@capbluecross.com](mailto:cbc.genacctunit-cashdisb@capbluecross.com)

**Fax the completed form to:** 717.651.8044

**To send the form via SecureMail, please go to [capbluecross.com](http://capbluecross.com):**

- Select *for health professionals*
- Select *Provider Services* (on the left)
- Select *Provider Services Home* (on the left)
- Select *Capital BlueCross SecureMail*

**Or simply click on the link provided below:**

[capbluecross.com/wps/wcm/connect/cbc-public/cbc/forhealthprofessionals/providerservices/providerserviceshome](http://capbluecross.com/wps/wcm/connect/cbc-public/cbc/forhealthprofessionals/providerservices/providerserviceshome)

**The provider must contact its financial institution to arrange for the delivery of the CORE required Minimum CCD + data elements needed for reassociation of the payment and the ERA. See Phase III CORE EFT & ERA Reassociation (CCD+/835) Rule Version 3.0.0.**

**Researching Missing/Late Files**

EFT files that have not been received after four business days of receipt of the corresponding ERA file can be researched by calling the designated Customer Service number for Professional Providers at 866.688.2242.