Capital BLUE

Electronic Data Interchange (EDI) Form

SEND FORM TO: Capital BlueCross (ATTN: Georganna M. Lerch)
PO Box 773631
Harrisburg, PA 17177-3631
Fax Number: 717-651-4001

This is to advise Capital BlueCross and its wholly owned affiliates that _____
(the "Provider") has appointed **Office Ally (014671)** (the "Agent") as our Agent for the following purposes:

(**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)

Description of Agency Purposes: **Submit 837P and/or 837I Claims to Capital Blue Cross**

List National Provider Identifiers (NPI) Covered by this Agency Agreement: _____
_____

NOTE: Professional Providers: please provide Type 2 – Organization NPI(s), not Type 1 – Individual NPI(s)
_____

Capital BlueCross is authorized to treat the Agent as though it is the Provider for the purposes noted above.

The Provider understands that Capital BlueCross will be relying on this representation for claims processing purposes and for purposes of releasing confidential information. Provider confirms that the Agent has signed a written agreement pursuant to which it has agreed to preserve any information which it receives from Capital BlueCross as confidential, and in accordance with all applicable laws and regulations.

Further, in consideration of Capital BlueCross' acceptance of the Agent, the Provider agrees that it will indemnify and hold Capital BlueCross harmless for any and all damages, claims and expenses that Capital BlueCross may incur or that may be asserted against Capital BlueCross as a result of the negligent or intentional actions of the Agent in carrying out its duties in connection with the purposes noted above.

Capital BlueCross shall be entitled to rely on this letter until revoked in writing.

Provider understands that Capital BlueCross reserves the right to modify its policies relating to the release of confidential information, including the release of subscriber information to providers or their Agents, at any time.

SIGNATURE _____ PRINT NAME _____
(Must be an Officer of the Provider)
TITLE _____ TELEPHONE _____

DATE _____ EMAIL _____