



Office Ally

MMM MULTI HEALTH (REFORM) (66065) EDI-ENROLLMENT INSTRUCTIONS

WHICH FORMS SHOULD I COMPLETE?

- Change Healthcare EDI Enrollment Form
- Assertus Provider Enrollment Form

WHERE SHOULD I SEND THE FORM(S)?

- Email the **Change Healthcare EDI Enrollment form** along with the **Assertus Provider Enrollment form** to batchenrollment@changehealthcare.com

WHAT IS THE TURNAROUND TIME?

- Standard Processing Time is approximately 14 days.

HOW DO I CHECK STATUS?

- Once you receive confirmation that you've been linked to Office Ally, you **MUST** call (360-975-7000) or email Support@officeally.com with the below information **PRIOR** to submitting claims electronically. Failure to do so will result in claim rejections.

Email Subject: MMM Multi Health (Reform) (66065) – EDI Approval

Body of Email:

Please log my EDI approval for First Medical Health Plan

- Provider Name:
- NPI:
- Tax ID:

Payer Information					
CPID	Payer ID	Payer	Type	Est Days	Multi CH
Special Enrollment Instructions					
Vendor Information					
Submitter ID	Submitter Name				
Provider Information					
Tax ID	NPI	Provider Number	Name		
Address			City	State	Zip
Contact Name				Contact Phone	
Contact Email Address					
Confirmation Addresses					
Primary Email Address			Secondary Email Address		
Report Method					
TSO ID	Report Type	Communication Protocol/Output	Report Format	Site ID	



**PROVIDER ENROLLMENT
TRANSMISSION AUTHORIZATION**

By completing and signing this authorization, the healthcare Provider is authorizing Assertus Holdings, LLC to interchange its electronic Healthcare transactions with the Trading Partner acting as a Delegate Transmission Site for the Healthcare Provider as reported hereunder.

Delegate Transmission Site CHC1		Site Account Number 581651222	NPI
Provider Name		Phone () - Ext.	Fax () -
Type <input type="checkbox"/> Solo Practitioner <input type="checkbox"/> Group Practice		Email	
Street Address		Postal Address <input type="checkbox"/> Same as Street Address	
	-		-
Notes:			
<p>Authorization</p> <p>Hereby, I certify that I'm the Provider referenced above or an authorized representative and that the reported NPI on this form belongs to the Provider referenced above, and I authorize ASSERTUS Holdings, LLC for the interchange of related health care transactions thru the Delegate Transmission Site reported on this form. I understand that this authorization will remain active until canceled in writing. I also understand that it is my responsibility to monitor that every claims file submitted to Assertus has a positive confirmation receipt received and that I need to report to Assertus any missing confirmation receipts.</p>			
Billing Provider Authorized Signature	Date:	ASSERTUS Authorized Signature	Date: