

# TRIPLE-S ADVANTAGE (973MA) 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 <u>Support@officeally.com</u> with the below information PRIOR to submitting claims electronically. Failure to do so will result in claim rejections.

**Email Subject**: Triple-S Advantage (973MA) – EDI Approval

**Body of Email:** 

Please log my EDI approval for First Medical Health Plan

- Provider Name:
- NPI:
- Tax ID:

Payer Information												
CPID	Payer	r ID	Payer			Туре	9	Est Days	Multi CH			
Special Enrollment Instructions												
				Vendor In	formation							
Submitte	er ID	Submitter Name										
Provider Information												
Tax ID		NPI		Provider Number	Name							
Address					City			State	Zip			
Contact							Contact	Phone				
Contact	Email A	Addre	ss									
				Confirmatio								
Primary	Addre	SS		Secondary Email Address								
Report Method												
TSO ID		Repo	rt Type	Communication Pro	tocol/Output Report Form		rmat	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.

					NPI				
Delegate Transmission Site		5	Site Account N	lumber					
CHC1		į	581651222						
Provider Name		F	Phone Fax						
		(	( )	- Ext.	( ) -				
Туре		E	Email						
☐ Solo Practitioner	☐ Group Practice								
Street Address		F	Postal Address Same as Street Address						
	-				-				
Notes:									
Authorization									
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.									
·									
Billing Provider Authorized Signature Date:			ASSERTUS Authorized Signature			Date:			