ALAMEDA ALLIANCE FOR HEALTH (95327)
ERA ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- Electronic Remittance Advice (ERA) Enrollment Form

WHERE SHOULD I SEND THE FORM(S)?

- Mail, fax or Email form to:

  Alameda Alliance for Health
  Attn: EDI Enrollment - IT Dept
  1240 South Loop Road
  Alameda, CA 94502

  Fax form to: (510) 747-4290

  Email form to: edisupport@alamedaalliance.org

WHAT IS THE TURNAROUND TIME FOR ERA ENROLLMENT?

- Standard Processing is 1 business day after receipt of enrollment.

HOW DO I CHECK STATUS?

- To check the status of your enrollment, send and email to edisupport@alamedaalliance.org to verify if you have been linked to Office Ally to receive your 835s.

1240 South Loop Road
Alameda, CA 94502

Tel: 510-373-5757
edisupport@alamedaalliance.org

ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT FORM

Thank you for your interest in receiving electronic remittance advice (ERA) from **Alameda Alliance for Health**. The first step in the ERA onboarding process is completion of the ERA Enrollment Form and Trading Partner Agreement below. Please complete these forms and mail, email or fax the forms to:

Alameda Alliance for Health

Attn: EDI Enrollment-IT Dept
1240 South Loop Road
Alameda, CA 94502
FAX: 510-747-4290
Email: edisupport@alamedaalliance.org

NOTE: ERA testing cannot be initiated until Alameda Alliance for Health has received your completed ERA Enrollment Form and Trading Partner Agreement.

PROVIDER INFORMATION

1. Company/Provider Name:

   _____

2. Doing Business As (DBA): (*Trade name, or fictitious business name, under which the business or operation is conducted and not the legal name of the legal person (or persons) who actually own it and are responsible for it)*

   _____

3. Provider Address: _____

   Phone #: _____Fax #: _____

4. National Provider Identifier (s): _____

   Group NPI: _____ Yes _____ No Individual NPI: _____ Yes _____ No

5. Provider Contact Information

Contact Person: (Name of a contact in provider office for handling ERA issues) _____

E-mail Address: _____

Telephone #: _____ Fax#: _____

6. Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier): (*Provider preference for grouping (bulking) claim payment remittance advice - must match preference for EFT payment. Select from below by marking 'X').*

TIN: _____ or NPI: _____

7. Method of ERA Retrieval: (*Select from below by marking 'X'*).

Download from AAH SFTP site: _____ Download from clearinghouse: X

Download from Vendor: _____

8. Provider's Clearinghouse Official Name: Office Ally, Inc via ClaimsNet

   Clearing house Contact :(for ERA issues) Customer Service

   Contact Phone Number: 360-975-7000 opt 1 Contact Email Address: support@officeally.com

   (*The provider must give Alameda alliance for Health written notice 30 days prior to terminating an active business Associate Agreement with its clearinghouse.*)

9. Provider Vendor Official Name: _____

   Vendor Contact: (for *ERA issues*) _____

   Contact Phone Number: _____ Contact Email Address: _____

10. Reason for Enrollment Submission: (*Select from below by marking 'X'*).

    New Enrollment: _____ Change enrollment: _____ Delete Enrollment: _____

Trading Partner agreement: (this should be signed by provider)

TRADING PARTNER AGREEMENT

This agreement is made between Alameda Alliance for Health ("Plan") and _____

("Trading Partner") as of _____day of _____, 20_____. This agreement provides the terms and conditions governing electronic transfers of data between Plan and Trading Partner (collectively "Parties"). Both Parties acknowledge and agree that the privacy and security of data held by or exchanged between them is of utmost priority. Both Plan and Trading Partner agree to take steps reasonably necessary to ensure that electronic transactions between them conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan's Electronic Data Interchange (EDI) Enrollment Form, and the then current version of the Plan companion guides. This agreement will remain in effect until terminated according to the terms listed in this agreement. This agreement cannot be altered or amended without a written statement signed by both Parties.

I. Term and Termination

This agreement will remain effective indefinitely beginning on the effective date of this agreement. Either Party may voluntarily terminate this agreement by providing written notice to the other Party thirty (30) days in advance of the termination date. If a Party breaches any material obligation of this agreement, the other Party may terminate this agreement immediately upon providing written notice to the other Party.

II. Obligations of the Parties

1. Each Party will be responsible for and take reasonable care to ensure that the information submitted in each electronic transaction by itself, its employees, or its agents is accurate, complete and truthful.

2. Each Party will take reasonable precautions to limit the disclosure of the electronic data to authorized personnel on a need-to-know basis. Company and Trading Partner will notify the other Party of a termination of its relationship with a previously authorized employee

or vendor (i.e., clearinghouse), that may require action to foreclose submission and receipt of transactions by person or vendor no longer authorized to act on its behalf.

3. Parties will not disclose the electronic data to any other person or organization without the express written permission of the subject of the data (i.e., the Plan's member or the Trading Partner's patient/customer) unless such disclosure is permissible by State or Federal law. Plan and Trading Partner will notify the other Party if it becomes aware of any use or disclosure that is not expressly permitted by this agreement.

4. Each Party will treat the information sent and received electronically as proprietary and will not use the information for any purpose or in a manner that would violate any privacy, security, or confidentiality laws or regulations including, but not limited to, the HIPAA law. Each party will put appropriate safeguards in place to protect patient specific data from improper access and will maintain the confidentiality of any security access codes.

5. Both Parties must agree that adequate testing has been completed before "live," production submissions will be transmitted or accepted to or from the other Party.

6. Plan and Trading Partner will not consider the other Party's electronic submission "received" (and will not "date stamp" the transaction) until the file has passed the Plan's initial edits.

7. Each Party will pay its own costs, charges, or fees it may incur as a result of transmitting electronic transactions to, or receiving electronic transactions from, the other Party.

8. Each Party will retain all original source documentation that supports the electronic data submission for at least six years and as required by applicable state and federal laws. Plan and Trading Partner shall have access to the other Party's original source documentation for auditing and verification purposes. Both Parties will research and correct any data discrepancies at its own expense. If a discrepancy is identified in either Party's original source documentation, both Parties agree to implement corrective action that will ensure an accurate and prompt resolution which may include adjusting any incorrect payments identified as a result of such audit. Anyone who misrepresents or falsifies information relating to a claim may, upon conviction, be subject to fines and/or imprisonment under Federal law.

9. Plan and Trading Partner will notify the other Party promptly if any transmitted data is received in an unintelligible or garbled form. Both Parties agree to retransmit the original transmission if a data transmission is lost or indecipherable.

10. Plan agrees to provide an acknowledgement of receipt of the Trading Partner's electronic data submission.

III. Indemnification

Plan and Trading Partner shall hold harmless and indemnify the other Party from any and all claims, liabilities, judgments, damages or judgments asserted against, imposed upon or incurred due to its own negligence, intentional wrongdoing, or violation of this agreement.

IV. Authorized Signature

I am authorized to sign this agreement on behalf of said Trading Partner. I have read and agree to the foregoing provisions and acknowledge the same by signing below.

Alameda Alliance for Health Trading Partner

By: _____

Title: _____

Date: _____

Network Access Request for FTPS - EXTERNAL

Alameda Alliance has implemented a Secure, HIPAA compliant file transfer website. This website will allow our trading partners to securely send and receive Protected Health Information to Alameda Alliance for Health.

For initial account setup, please email a completed form to ishelpdesk@alamedaalliance.org.

Please allow 5 to 10 business days for a response.

Once approved, we will send a confirmation email with instructions on using the website. Should you have questions, please call the **Service Desk** at (510) 747-4520. FAX completed and signed form to: 510-747-4290

Requestor Information:

First Name		Last Name	
Title		Company Name	
Email Address		Phone Number	
Fax Number		Business Address	
Ext. IP Address		Submission date	
Nature of Work		**Request Type**	**One-Time [ ] Re-Occurring [ ]**

Requestor's Manager's Information:

First Name		Last Name	
Title		Phone Number	
Email Address			

Requestor's IT Contact Information:

First Name		Last Name	
Title		Phone Number	
Email Address			

Alameda Alliance for Health Contacts (referred by):

Primary Contact Name	Yash Doshi
Secondary Contact Name	

Confidentially Statement:

- I agree not to share my password, leave terminal sessions logged in under my name for others to use, or otherwise share access under my privileges. I understand that my logon name and password constitutes an electronic signature under California law.
- I agree to access only members for whom I am providing assistance or for whom I can demonstrate a need to know.
- I agree to maintain the confidentiality of medical information and will abide by the Alameda Alliance for Health security and confidentiality policies.

Requestor's Signature: _____

Alliance Supervising Manager Signature: _____

For Alameda Alliance for Health Use Only

File Type		**Automation**	**Yes [ ] No [ ]**
Staging Location		**Schedule**	**Daily [ ] Weekly [ ] Monthly [ ]**
FTP Account Name		**Process Type**	**In [ ] Out [ ] Both [ ]**