

**WHICH FORMS SHOULD I COMPLETE?**

- **Electronic Remittance Advice Enrollment Form** (pg. 2-3)
  - o Additional instructions for this form on Pg. 4

**WHERE SHOULD I SEND THE FORM(S)?**

- Email to [ICS@azblue.com](mailto:ICS@azblue.com)
- Fax to (602) 864-3135

**WHAT IS THE TURNAROUND TIME?**

- Activation may take up to 30 calendar days.

**HOW DO I CHECK STATUS?**

- If you have questions regarding your enrollments processing, please contact BCBSAZ Integrated Solutions at [ICS@azblue.com](mailto:ICS@azblue.com).



An Independent Licensee of the Blue Cross and Blue Shield Association

# Electronic Remittance Advice (ERA) Enrollment Form

## PROVIDER INFORMATION

Provider Name	Doing Business As Name (DBA)
---------------	------------------------------

## PROVIDER ADDRESS

Street	City	State/Province	Zip Code/Postal Code
--------	------	----------------	----------------------

## PROVIDER IDENTIFIERS

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	National Provider Identifier (NPI)
--	------------------------------------

## OTHER IDENTIFIERS

Trading Partner ID 00008368
--------------------------------

## PROVIDER CONTACT

Provider Contact Name	Telephone Number	Telephone Number Extension
-----------------------	------------------	----------------------------

Email Address	Fax Number
---------------	------------

## PROVIDER AGENT

Provider Agent Name
---------------------

Provider Agent Contact Name	Telephone Number	Telephone Number Extension
-----------------------------	------------------	----------------------------

Email Address	Fax Number
---------------	------------

## ERA RETRIEVAL INFORMATION

### PREFERENCE FOR AGGREGATION OF REMITTANCE DATA (E.G. ACCOUNT NUMBER LINKAGE TO PROVIDER IDENTIFIER)

<input type="checkbox"/> Provider Tax Identification Number (TIN)	<input checked="" type="checkbox"/> National Provider Identifier (NPI)
---	--

Method of Retrieval	<input type="checkbox"/> CORE Web Service	<input type="checkbox"/> MyFileGateway	<input type="checkbox"/> SFTP – Trading Partner hosted
	<input type="checkbox"/> SFTP – BCBSAZ hosted	<input type="checkbox"/> FTP – Trading Partner hosted	<input type="checkbox"/> FTPS – Trading Partner hosted

## ERA CLEARINGHOUSE INFORMATION

Clearinghouse Name Office Ally	Clearinghouse Contact Name Payer Enrollment
-----------------------------------	--

Telephone Number (360) 975-7000	Email Address PayerEnrollment@officeally.com
------------------------------------	---

## ERA VENDOR INFORMATION

Vendor Name
-------------

## ENROLLMENT SUBMISSION/AUTHORIZATION

Reason for Submission	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Change Enrollment	<input type="checkbox"/> Cancel Enrollment
-----------------------	---	--	--

PLEASE NOTE: Provider needs to contact their Financial Institution to arrange for secure delivery of the Automated Clearing House (ACH) Payment Related Information for all Corporate Credit or Debit with Addenda Record (CCD+) EFT payments (Electronic Funds Transfer) to enable reassociation with ERAs.

## AUTHORIZED SIGNATURE

Electronic Signature of Person Submitting Enrollment	Written Signature of Person Submitting Enrollment
--	---

Printed Name of Person Submitting Enrollment	Printed Title of Person Submitting Enrollment
--	---

Submission Date / /
------------------------

SUBMIT BY EMAIL

## INSTRUCTIONS

---

Return this completed enrollment form by email to [Blue Cross Blue Shield of Arizona \(BCBSAZ\) Integrated Solutions at ICS@azblue.com](mailto:BCBSAZ.Integrated.Solutions@azblue.com) (use subject line: ERA Enrollment) or by fax to (602) 864-3135. See below for instructions on how to fill out the form.

Activation may take up to 30 calendar days. If you have questions, please contact [BCBSAZ Integrated Solutions at ICS@azblue.com](mailto:BCBSAZ.Integrated.Solutions@azblue.com).

## PROVIDER INFORMATION

---

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

**Doing Business As Name (DBA)** – A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it. **Provide this information only if applicable.**

**Provider Address** – **Street:** The number and street name where a person or 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 Country. **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 Identifiers** – **Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):** 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 healthcare providers. Covered healthcare providers and all health plans and healthcare 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 healthcare 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.

**Other Identifiers** – **Trading Partner ID** is the provider’s submitter ID assigned by the health plan or the provider’s clearinghouse or vendor.

## PROVIDER CONTACT

---

**Provider Contact Name** – Name of a contact in provider office for handling ERA issues. **Telephone Number** associated with contact person. **Email Address** at which the health plan might contact the provider. **Fax Number** at which the provider can be sent facsimiles.

## PROVIDER AGENT

---

**Provider Agent Name** – Name of provider’s authorized agent.

**Provider Agent Contact Name** – Name of a contact in the agent office for handling ERA issues. **Telephone Number** associated with contact person. **Email Address** at which the health plan might contact the provider. **Fax Number** at which the provider can be sent facsimiles.

## ERA RETRIEVAL INFORMATION

---

**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. BCBSAZ bundles payments only by NPI.

**Method of Retrieval** – The method in which the provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.)

CORE (Committee on Operating Rules for Information Exchange) • SFTP (Secure File Transfer Protocol) • FTP (File Transfer Protocol) • SFTPS (Secure File Transfer Protocol) • FTSPS (File Transfer Protocol Secure)

## ERA CLEARINGHOUSE INFORMATION

---

**Clearinghouse Name** – Official name of the provider’s clearinghouse.

**Clearinghouse Contact Name** – Name of a contact in clearinghouse office for handling ERA issues. **Telephone Number** of contact. **Email Address** at which the health plan might contact the provider’s clearinghouse.

## ERA VENDOR INFORMATION

---

**Vendor Name** – Official name of the provider’s software vendor.

## ENROLLMENT SUBMISSION/AUTHORIZATION

---

**Contact Your Financial Institution** – If you are enrolling in EFT, you must contact your Financial Institution to arrange for secure delivery of the ACH Payment Related Information for all CCD+ EFT payments to enable reassociation with ERAs.


**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.



An Independent Licensee of the Blue Cross and Blue Shield Association

# Helpful tips for completing Electronic Remittance Advice (ERA) Enrollment



**BlueCross  
BlueShield  
of Arizona**

An Independent Licensee of the Blue Cross and Blue Shield Association

## Electronic Remittance Advice (ERA) Enrollment Form

PROVIDER INFORMATION			
Provider Name		Doing Business As Name (DBA)	
PROVIDER ADDRESS			
Street	City	State/Province	Zip Code/Postal Code
PROVIDER IDENTIFIERS			
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)		National Provider Identifier (NPI)	
OTHER IDENTIFIERS			
Trading Partner ID			
PROVIDER CONTACT			
Provider Contact Name		Telephone Number	Telephone Number Extension
Email Address		Fax Number	
PROVIDER AGENT			
Provider Agent Name			
Provider Agent Contact Name		Telephone Number	Telephone Number Extension
Email Address		Fax Number	
ERA RETRIEVAL INFORMATION			
PREFERENCE FOR AGGREGATION OF REMITTANCE DATA (E.G. ACCOUNT NUMBER LINKAGE TO PROVIDER IDENTIFIER)			
<input type="checkbox"/> Provider Tax Identification Number (TIN)		<input checked="" type="checkbox"/> National Provider Identifier (NPI)	
Method of Retrieval			
<input type="checkbox"/> CORE Web Service	<input type="checkbox"/> MyFileGateway	<input type="checkbox"/> SFTP – Trading Partner hosted	
<input type="checkbox"/> SFTP – BCBSAZ hosted	<input type="checkbox"/> FTP – Trading Partner hosted	<input type="checkbox"/> FTSP – Trading Partner hosted	
ERA CLEARINGHOUSE INFORMATION			
Clearinghouse Name		Clearinghouse Contact Name	
Telephone Number		Email Address	
ERA VENDOR INFORMATION			
Vendor Name			
ENROLLMENT SUBMISSION/AUTHORIZATION			
Reason for Submission			
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Enrollment <input type="checkbox"/> Cancel Enrollment			
<small>PLEASE NOTE: Provider needs to contact their Financial Institution to arrange for secure delivery of the Automated Clearing House (ACH) Payment Related Information for all Corporate Credit or Debit with Addenda Record (CCD+) EFT payments (Electronic Funds Transfer) to enable reassociation with ERAs.</small>			
AUTHORIZED SIGNATURE			
Electronic Signature of Person Submitting Enrollment		Written Signature of Person Submitting Enrollment	
Printed Name of Person Submitting Enrollment		Printed Title of Person Submitting Enrollment	
Submission Date			
/ /			

SUBMIT BY EMAIL

- A. Supply the provider name.**
- B. Supply your Federal Tax ID number and National Provider Identifier (NPI).**
- C. Supply the provider contact name, telephone number and email address.**
- D. Supply the name of the Clearinghouse used for ERA transaction.**
- E. Please choose reason for submission, sign (either written or electronic), print your name and submission date.**
- F. Reminder - If you are also enrolling in EFT, you must contact your Financial Institution to arrange for secure delivery of the ACH Payment Related Information for all CCD+ EFT payments to enable reassociation with ERAs.**