

WHICH FORMS SHOULD I COMPLETE?

- EDI Trading Partner Enrollment Form

WHERE SHOULD I SEND THE FORM(S)?

- Email form to payerenrollment@officeally.com
 - o **Subject Line:** BCBS MA ERA Enrollment – (insert Provider NPI)

WHAT IS THE TURNAROUND TIME?

- Standard Processing Time is 2-5 Business Days.
- The time it takes ERAs to start coming through is dependent upon the payer. Generally, ERAs begin coming through anywhere from within 10-45 business days.

HOW DO I CHECK STATUS?

- Once your enrollment has been processed and approved at the payer, you will receive an email confirming the approval from Office Ally.



MASSACHUSETTS

EDI Trading Partner Enrollment Form

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

SUBMITTER REQUEST			
Type of request	New <input checked="" type="checkbox"/>	Update <input type="checkbox"/>	Cancel <input type="checkbox"/>
			Cancel Date

GENERAL/DEMOGRAPHIC INFORMATION			
Date of Request	Submitter ID (assigned by BCBSMA)		00095BCBS
Submitter Name	Office Ally, LLC		
Address 1	16703 SE McGillivray Blvd. Suite 200		
Address 2			
City	Vancouver	State	WA Zip Code 98683
Please indicate if you are a Billing Service or Clearinghouse		Billing Service <input type="checkbox"/>	Clearinghouse <input checked="" type="checkbox"/>

SYSTEM/SOFTWARE	
Practice Management System/Software products (if applicable)	
Please indicate if you use NEHEN to submit claims/receive remittances	
Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

CONTACT INFORMATION			
Primary Contact Name	EDI Enrollment Department	Title	Enrollment Success Department
Telephone #	726-201-4362	Fax #	360-896-2151
Email Address	payerenrollment@officeally.com		
Technical Contact Name	Cara Trahey	Title	EDI Enrollment Manager
Telephone #	726-201-4362	Fax #	360-896-2151
Email Address	cara.trahey@officeally.com		

TRANSACTIONS (Version 4010A1) (5010 Version effective 01/01/2012)			
Ⓢ INDIVIDUAL FORMS MUST BE COMPLETED FOR EACH CLAIM TYPE REQUESTED.			
Transaction Type	837I <input checked="" type="checkbox"/>	837P <input type="checkbox"/>	837D <input type="checkbox"/> 835 <input checked="" type="checkbox"/>
Proposed Test Date	5/10/2010		
Target Production Date	6/01/2010		

PROVIDER INFORMATION			
Ⓢ REQUIRED. Please include all Billing Providers below for which you intend to submit claims transactions.			
Ⓢ Additional Providers can be entered on Page 3 of this form.			
Provider Name	National Provider Identifier	Federal Tax Identifier	835
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>
			Yes <input type="checkbox"/>

Questions? Send an email to EDISupport@bcbsma.com with "Enrollment Questions" in the Subject line.

Instructions: Complete this form

- Email to: EDISupport@bcbsma.com
- Indicate “Enrollment Form” and your Submitter ID in the Subject line
- The EDI Support Team will contact you within 2 business days

