Office Ally

BCBS OF SOUTH CAROLINA (BCSSC) ERA-ENROLLMENT INSTRUCTIONS

WHICH FORMS SHOULD I COMPLETE?

- **Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) Enrollment** (Pg. 2-3)
- **Clearinghouse ERA Enrollment Form** (Pg 4-5)

WHERE SHOULD I SEND THE FORM(S)?

- Email the ERA/EFT Enrollment to provider.eft@bcbssc.com
- Email the Clearinghouse ERA Enrollment Form to edi.services@bcbssc.com

HOW DO I CHECK STATUS?

- To check status of your ERA enrollment send an email to provider.eft@bcbssc.com asking if your ERAs have been linked to Office Ally's Submitter ID, **CGW0489CA3**.

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

BlueChoice HealthPlan South Carolina

An independent licensee of the Blue Cross and Blue Shield Association

Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) Enrollment

Provider Information

Provider's Name: ____ **National Provider Identifier (NPI):** _________________

Provider's Address: ____

____

____

Provider's Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): _________________________

Provider's Contact Information

Provider's Contact Name: ____

Job Title: ____

Telephone Number: (______) _______-_______________ Ext: ___________

Email Address: ____

Financial Institution Information

Financial Institution's Name: ____

Street: ____

City: __________________________ **State:** ___________ **ZIP Code:** ____________

Financial Institution's Telephone Number: (_____) ______-_______ Ext: __________

Financial Institution's Routing Number: ____________________________________

Type of Account at Financial Institution: Checking: _____ **Savings:** _____

Provider's Account Number with Financial Institution: ________________________________

Enrollment

New Enrollment: Select if you do not currently receive EFTs from us and need to add a bank account.
Change Enrollment: Select if you already receive EFTs from us and need to update your bank account.

Choose Enrollment Type: **New Enrollment:** _______

Change Enrollment: _______

Requested EFT Start/Change Date (mm/dd/yyyy)*: _____/_______/_________

**Please note when a new bank account is loaded, it requires a test period. Testing can last two to four weeks, depending on how often you file claims. You will receive an email from the EFT department with your new EFT effective date once your enrollment has been completed.*

Signature

Return completed form by email to provider.eft@bcbssc.com

For more information contact provider.eft@bcbssc.com.

Authorized Signature: ____

TERMS AND CONDITIONS FOR ELECTRONIC PAYMENT

By signing below, your company agrees to accept payment by BlueCross BlueShield of South Carolina and/or BlueChoice HealthPlan of South Carolina (BlueCross/BlueChoice HealthPlan), through electronic funds transfers (EFT). Additionally, you acknowledge and agree that all payments shall be made in accordance with the information that you supply on the Electronic Funds Transfer Authorization Form and that BlueCross and/or BlueChoice HealthPlan shall be entitled to rely exclusively upon such information. The terms and conditions outlined herein shall apply to and amend all existing agreements between you and BlueCross BlueShield of South Carolina and/or BlueChoice HealthPlan and/or Companion Benefit Alternatives by incorporating the following terms and conditions for electronic payment. On behalf of BlueCross BlueShield of South Carolina and BlueChoice HealthPlan, Companion Benefit Alternatives (CBA) administers behavioral health benefits. CBA is a separate company.

BlueCross/BlueChoice HealthPlan will initiate payment to you based on the following:

1. The electronic funds transfer will be made to the financial institution and account number indicated on your Electronic Funds Transfer Authorization Form.
2. BlueCross/BlueChoice HealthPlan will make payments in accordance with and be governed by the National Automated Clearinghouse Association's Corporation Trade Payment Rules. Our process is governed by and in accordance with the laws, other than choice of law provision of any particular contract, of South Carolina, including Article 4A of the Uniform Commercial Code as enacted by South Carolina and amended from time to time.
3. The information you provide on the Electronic Funds Transfer Authorization Form is very important. **You understand that you must communicate any change in the information to BlueCross/BlueChoice HealthPlan. This communication must be in the form of a new Electronic Funds Transfer Authorization Form returned by fax at 803-870-8065, (attn. EFT Coordinator), or by email to provider.eft@bcbssc.com.**

   BlueCross/BlueChoice HealthPlan/Companion Benefit Alternatives shall not be liable for any loss, which may arise solely by reason of error, mistake or fraud regarding this information.
4. Payment shall be made pursuant to the terms of the commercial agreement(s) you have executed with BlueCross and/or BlueChoice HealthPlan. The terms and conditions of the Electronic Funds Transfer Authorization Form neither expand nor diminish the respective rights and obligations of any applicable commercial agreement you have executed with BlueCross and/or BlueChoice HealthPlan. The payment due date is not affected. We will consider payment made when your financial institution has received or has control of the payment transaction. This will generally occur within three calendar days following initiation by BlueCross/BlueChoice HealthPlan.

   If payment is initiated on a non-banking day at BlueCross/BlueChoice HealthPlan's originating bank, the funds transfer will occur the following banking day. In all cases, "Banking Day" is defined as the day on which both trading partners' banks are available to transmit and receive these funds transfers.
5. BlueCross/BlueChoice HealthPlan has the right to adjust future payments if payments previously made are found to be duplicates, in excess of requirements, fraudulent or in error.
6. With respect to the EFT reimbursement process, BlueCross/BlueChoice HealthPlan shall be responsible up to the point when your financial institution receives or has control of the transaction. Any loss of data at or after that point will be borne by you unless the loss is due solely to negligence of BlueCross/BlueChoice HealthPlan or its originating bank.

   You should notify BlueCross/BlueChoice HealthPlan immediately via fax if payment is not received as described in item #4 (above). On receipt of a returned Automated Clearinghouse notification from the applicable bank, BlueCross/BlueChoice HealthPlan shall have reasonable time (not to exceed 10 business days) to make any payment.

   Your signature below constitutes a waiver on behalf of your company of any further notice related to institution of payment through EFT, and your company agrees to accept such change upon BlueCross/BlueChoice HealthPlan's receipt of this executed document as well as the EFT Authorization Form enclosed herein. If you contend payment through EFT is adverse to your company, please provide written notice of such to the fax number in #3 above immediately and in any event, no later than within 30 days.

NAME: ______________________________ SIGNATURE: ______________________________
(Print)

TITLE: ______________________________ DATE: ______________________

GROUP NAME: __________________________ TAX ID: ______________________

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ERA ENROLLMENT FORM
FOR PROVIDERS USING A CLEARINGHOUSE

Please return completed form to edi.services@bcbssc.com

I hereby authorize ________Office Ally________ to receive 835 Electronic Remittance Advices (ERAs) on my behalf. I am authorized to endorse this ERA enrollment form on behalf of my company. I acknowledge that it is my responsibility to notify BlueCross BlueShield of South Carolina in writing if I wish to change or revoke this authorization.

NOTE: Use Page 2 **only** if additional offices *under same Tax Id* will be receiving ERAs.

Fields marked with an asterisk (*) are required. Incomplete or illegible forms will be returned.

BILLING PROVIDER TAX ID NUMBER*	SUBMITTER ID NUMBER *(Internal BCBSSC Use Only)* CGW0489CA3
BILLING PROVIDER NPI NUMBER*	BILLING PROVIDER CONTACT NAME/TITLE (Please Print) *
BILLING PROVIDER NAME*	BILLING PROVIDER CONTACT SIGNATURE*
BILLING PROVIDER ADDRESS *(Cannot be P.O Box)* *	DATE*
BILLING PROVIDER CITY/STATE/ZIP*	BILLING PROVIDER PHONE NUMBER*
	BILLING PROVIDER EMAIL ADDRESS*
	CLEARINGHOUSE EMAIL ADDRESS (Optional) payerenrollment@officeally.com

For questions or concerns, contact BCBSSC EDI Services at edi.services@bcbssc.com

mvh 05/01/22

Complete this page **only** if additional offices (unique *billing NPI numbers under same Tax ID*) will be receiving ERAs.

Tax ID Number	NPI Number	Name and Location

For questions or concerns, contact BCBSSC EDI Services at edi.services@bcbssc.com