BLUE CROSS BLUE SHIELD MONTANA (BCSMT) ERA ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

Note: Enrollment for both Health Economic Livelihood Partnership (HELP) and Blue Cross Medicare Adv IL, MT, NM, OK, and TX are required in order to receive ERAs for BCBS of Montana.

- Electronic Remittance Advice ERA Enrollment form
- Advanced Electronic Remittance Advice Enrollment

WHERE SHOULD I SEND THE FORM(S)?

- Fax the **Electronic Remittance Advice (ERA) Enrollment form** to (312) 946-3500
- Email the **Advanced Electronic Remittance Advice Enrollment form** to aacenrollment@availity.com

WHAT IS THE TURNAROUND TIME FOR ERA ENROLLMENT?

- Standard processing time is 30 days

BlueCross BlueShield of Montana

Electronic Remittance Advice (ERA) Enrollment Form

Prior to enrolling for ERA, you must be registered with Availity™. Availity, LLC supports the exchange of electronic remittances in the ASC X12 835, version 5010A1 format. The ERA enrollment process establishes an electronic mailbox where Availity will place the electronic remittance file(s) received from payer(s). The provider's Federal Tax ID is required to establish an ERA Receiver mailbox and also will be used to parse remittance transactions from the payer. There is no charge to register with Availity. Visit availity.com for details.

If you are a billing service or clearinghouse requesting to receive the ERA on behalf of a provider, the provider must complete the enrollment documents authorizing you to retrieve their remittance files, or a copy of the Power of Attorney must be submitted with the enrollment form.

This ERA Enrollment Form will be used to activate ERA delivery related to all claims submitted by/on behalf of the enrolling provider, once claims are finalized.

If you have any questions regarding the ERA enrollment process, contact the Blue Cross and Blue Shield of Montana (BCBSMT) Electronic Commerce Center at ecommercehotline@bcbsil.com or 800-746-4614. Return your completed, signed form via fax to 312-946-3500.

For commercial claims, the paper Provider Claim Summary (PCS) currently provided by BCBSMT will be discontinued 31 days after your ERA enrollment is processed. For government programs claims, the PCS will continue to be mailed. Additional information, including how to obtain enrollment status, is available on our website at bcbsmt.com/provider.

Complete all fields on pages 1 and 2 of this form. To fill out online, use the tab key to advance from field to field. Once completed, print, sign and fax your form to the BCBSMT Electronic Commerce Center, as noted above.

PROVIDER INFORMATION

Provider Name:				
Provider Address:	Street:	City:	State/Province:	Zip Code/Postal Code:

PROVIDER IDENTIFIERS INFORMATION

Provider Identifiers:	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):	
National Provider Identifier (NPI): (Billing NPI – must be 10 digits)	

PROVIDER CONTACT INFORMATION

Provider Contact Name:		Title:	
Telephone Number:		Telephone Number Extension:	
Email Address: *(Required, if applicable)*		Fax Number:	

ELECTRONIC REMITTANCE ADVICE INFORMATION

Preference for Aggregation of Remittance Data: *(Select one)*	☐ Provider Tax Identification Number (TIN)	☐ National Provider Identifier (NPI)

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

Clearinghouse Name:	Office Ally, Inc

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION

Vendor Name:	

SUBMISSION INFORMATION

Reason for Submission: *(Select one)*	☐ New Enrollment	☐ Change Enrollment	☐ Cancel Enrollment
Authorized Signature:			
Printed Name of Person Submitting Enrollment:			
Printed Title of Person Submitting Enrollment:			
Submission Date:			

(Please continue to page 2 to complete *Other Data*, including *Receiver/Additional information*.)

OTHER DATA

In addition to the maximum data elements required for ERA enrollment, BCBSMT will need the following information to finalize your request:

RECEIVER INFORMATION

Indicate who will receive the ERA file:

☐ Provider	☐ Billing Service	☑ Clearinghouse	☐ Other *(Please specify:)*

Availity Customer ID:	11904
Receiver Name:	Office Ally, Inc

Receiver Address:	Street:	City:	State/Province:	Zip Code/Postal Code:
	PO Box 872020	Vancouver	WA	98684

Indicate who will receive the Electronic Payment Summary (EPS) file *(select one)*:

☑ The EPS should go to the ERA Receiver indicated above.

OR

☐ *I need a separate mailbox for my EPS file.**

*Please provide the Availity Customer ID for separate delivery of the EPS:	

ADDITIONAL INFORMATION

☐ *I would like to receive Blue Plan Secondary Payer ERAs (Medicare Primary) from states other than Illinois, Montana, New Mexico, Oklahoma and Texas.*

Advanced Electronic Remittance Advice Enrollment

Availity™

Rev. 09.15.2016.1

PAYER INFORMATION	Refer to the Availity Health Plan Partner List for payer IDs.
Payer Name: BCBS Montana	Payer ID: 00751
Payer Name: HEALTH ECONOMIC LIVELIHOOD PARTNERSHIP (HELP)	Payer ID: 66004
Payer Name: Blue Cross Medicare Adv IL MT NM OK TX	Payer ID: 66006
Payer Name:	Payer ID:
Payer Name:	Payer ID:

RECEIVER INFORMATION	* If different than provider contact information.
Who will receive your ERA files? ☐ Provider ☒ Clearinghouse ☐ Vendor	
Receiver Name: Office Ally, Inc.	Availity Customer ID: 11904
Contact Name*: Customer Service	
Telephone Number*: (360) 975-7000 Ext: Opt 1	E-mail Address*: enrollmentadmin@officeally.com

PROVIDER INFORMATION			PROVIDER IDENTIFIERS INFORMATION
Provider Name:			Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):
Street:			
City:	State/Province:	ZIP Code/Postal Code:	National Provider Identifier (NPI):
Provider Name:			Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):
Street:			
City:	State/Province:	ZIP Code/Postal Code:	National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION	
Provider Contact Name:	
Telephone Number:	E-mail Address:

ELECTRONIC REMITTANCE ADVICE INFORMATION	
Preference for Aggregation of Remittance Data	☐ Provider Tax Identification Number (TIN):
	☐ National Provider Identifier (NPI):

SUBMISSION INFORMATION			
Reason for Submission:	☐ New Enrollment	☐ Change Enrollment	☐ Cancel Enrollment

Authorized Signature:

Important: By typing or signing a name in this field, you acknowledge and agree that you have been authorized by the provider or its agent to initiate, modify, or terminate an enrollment. You further acknowledge and agree that you have the legal authority to perform such action on behalf of your organization. In no event will Availity be liable for any losses or damages including without limitation, indirect or consequential losses or damages, or any loss or damage whatsoever arising from loss of data or profits arising out of, or in connection with this submission.

Printed Name of Person Submitting Enrollment:	Submission Date:

SEND THE FORM VIA:	E-mail: E-mail Form	Fax: 317.580.0027	Mail: Avality LLC P.O. Box 550857 Jacksonville, FL 32255-0857