CENTRAL CALIFORNIA ALLIANCE FOR HEALTH (CCA01) PRE-ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- EDI Claims Enrollment Form

WHERE SHOULD I SEND THE FORM(S)?

- Email the form to edisupport@ccah-alliance.org; OR
- Fax to (831) 430-5895 Attn: EDI Analyst

HOW CAN I CHECK THE STATUS?

- Email edisupport@ccah-alliance.org or call (800) 700-3874 ext 5510.
- Once the enrollment is complete, CCAH will notify both Office Ally and the provider.

EDI CLAIMS ENROLLMENT FORM

IDENTIFICATION OF PROVIDER/TRADING PARTNER AND TRANSACTION INFORMATION

All Trading Partners, whether covered entities or business associates of covered entities, agree to abide by all HIPAA Privacy and Security requirements as they apply to communications with The Alliance.

Reminder: Prior to setting up Electronic Data Interchange (EDI) claims submission with the Alliance, a minimum of one paper claim must have been submitted to the Alliance so that a record for the office can be configured.

PROVIDER INFORMATION (All fields required)

Provider Name		Provider Federal Tax Identification Number (TIN)	
Doing Business As Name (DBA)		National Provider Identifier (NPI)	
Provider Address – Street	City	State/Province	ZIP Code/Postal Code
Provider Contact Name	Telephone Number ( )	Email Address	

CLEARINGHOUSE INFORMATION (Required field)

Are you planning to use a clearinghouse for electronic transmissions with the Alliance?	☒ Yes	Clearinghouse Name: Office Ally, Inc (330897513)	☐ No

BILLING SERVICE/VENDOR INFORMATION (Required field)

Do you currently use a billing service/vendor?	☐ Yes	Billing Service/Vendor Name	☐ No

SUBMISSION INFORMATION (Required field)

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

TRANSMISSION INFORMATION (Select appropriate fields)

☒ **Health Care Claim: Professional (837)** (ASC X12N 005010X222)	☒ **Health Care Claim: Institutional (837)** (ASC X12N 005010X0223)
☒ **Health Care Claim Payment/Advice (ERA) (835)** (ASC X12N 005010X221)	
☐ **Health Care Eligibility Benefit Inquiry & Response (270/271)** (ASC X12N 005010X279A1) ***Check with your clearinghouse for availability***	☐ **Health Care Claim Status Request & Response (276/277)** (ASC X12N 005010X212) ***Check with your clearinghouse for availability***

AUTHORIZED SIGNATURE (Person submitting form)

Name	Signature	Submission Date

Please EMAIL completed form to
edisupport@ccah-alliance.org

Or FAX to (831) 430-5895, ATTN: EDI Analyst

For questions about this form, please call the EDI Support Group at (800) 700-3874 x5510

May 2018