BCBS OF MISSISSIPPI (00230)
EDI-ENROLLMENT INSTRUCTIONS

WHICH FORMS/PROCESS SHOULD I COMPLETE?

- **Agreement between Blue Cross & Blue Shield of Mississippi, Clearinghouse and Provider**

WHERE DO I SUBMIT THE FORM?

- Fax the form to (601) 936-5886; or
- Mail form to:
    - Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company
      ATTN: EDI Services
      PO BOX 1043
      Jackson, MS 39215

WHAT IS THE TURNAROUND TIME?

- Standard Processing Time is 2-5 business days.

HOW DO I CHECK STATUS?

- You must call BCBS Mississippi EDI at (800) 826-4068 to confirm you are linked to Office Ally.

- Once you receive confirmation that you have been linked to Office Ally, you MUST email payerenrollment@officeally.com with the below information PRIOR to submitting claims electronically:
    - Email Subject: BCBS Mississippi (00230) – EDI Approval_(insert NPI)
        - Body of Email:
            - Please log my EDI approval for BCBS Mississippi
                - Provider Name
                - Provider NPI
                - Tax ID
                - Submitter ID assigned by BCBS Mississippi (starts with S5144)

BlueCross BlueShield of Mississippi

It's good to be Blue.

AGREEMENT BETWEEN

BLUE CROSS & BLUE SHIELD OF MISSISSIPPI,
A MUTUAL INSURANCE COMPANY,

[CLEARINGHOUSE OR BILLING AGENCY]

AND

[PROVIDER]

THIS AGREEMENT made and entered into on this, the _____ day of _____, 20__, by and between BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, A Mutual Insurance Company, hereinafter referred to as the "Plan" , Office Ally, Inc. a Clearinghouse or Billing Agency, hereinafter referred to as "Clearinghouse or Billing Agency" and _____, a Provider of Healthcare Services, hereinafter referred to as the "Provider".

W I T N E S S E T H:

IN CONSIDERATION of authorizing the Provider to submit claims for healthcare services electronically through the system referred to as Electronic Submission of Claims ("ESC"), the parties agree to adhere to the mutual promises and conditions set forth in the following sections:

I. TERMS

The Provider certifies and specifically agrees that:

A. All services rendered were performed by the Provider or under the Provider's supervision in its facility.

B. Authorization for payment to the Provider and for release of medical information has been fully executed by the patient. The required patient signature, or where applicable, appropriate signatures on behalf of patients, required physician certification/recertification, and PSRO certifications, where applicable, are on file and will be maintained by the Provider.

C. Properly filed source documents will be maintained by the Provider who agrees that the Plan, or its designees, have the right to audit and confirm any information submitted. Any incorrect payments which are discovered as a result of such an audit will be adjusted according to applicable provisions of the Social Security Act as amended, regulations, guidelines and provisions contained in the Plan's contracts, and Plan policy guidelines.

D. In the event the Provider discontinues its relationship with the Billing Agency or Clearinghouse, the Provider will notify the Plan immediately and will supply the successor Billing Agency's or Clearinghouse's name, address and contact personnel. Also, in the event of any such discontinuance, this Agreement will terminate immediately.

E. In the event a Billing Agency or Clearinghouse is authorized by the Provider to submit electronic claims in the Provider's behalf, a written contract will be secured between the parties detailing the Billing Agency or Clearinghouse's responsibilities to report information as directed by the Provider. A copy of the contract will be furnished to the Plan if requested. Both the Provider and the Billing Agency or Clearinghouse must maintain a record of all electronic claims submitted for payment.

F. Any Billing Agency or Clearinghouse must be authorized in writing by the Provider to submit claims, and must abide by the terms of this Agreement and enter into such an Agreement as required by the Plan.

G. Should the provider engage the services of a Billing Agency and not a Clearinghouse, The Provider and the Billing Agency agree that it is their obligation to research and correct any and all billing discrepancies caused by either of them and to hold the Plan harmless for any costs or expenses, including claims overpayments or other damages incurred as a result of such billing discrepancies.

H. The Provider and Billing Agency or Clearinghouse agree to hold harmless and indemnify the Plan from and against all suits or claims of liability and all damages arising from or alleged to arise from the Provider's, Billing Agency's or Clearinghouse's negligence.

I. Access to any and all claims data will be restricted to the Provider and its employees, the Billing Agency or Clearinghouse and its employees, the Plan, or any third party as deemed necessary by the Provider, so as to maintain confidentiality according to HIPAA privacy guidelines and to preclude the filing of fraudulent claims.

J. Provider will require any billing agency, clearinghouse or other such agent, that is permitted though an agreement with Provider to access Protected Health Information maintained by Plan, to provide reasonable assurance, evidenced by written contract, that such billing agency or clearinghouse will comply with the privacy and security obligations of Provider and Plan with respect to Protected Health Information maintained by Plan.

K. The Provider agrees that the submission of an electronic claim is a claim for payment and that it assumes sole liability for misrepresentation or falsification of any record or other information essential to that claim or that is required pursuant to this Agreement if such misrepresentation or falsification is made by the Provider.

L. The Billing Agency or Clearinghouse agrees that the submission of an electronic claim is a claim for payment and that it assumes sole liability for misrepresentation or falsification of any record or other information essential to that claim or that is required pursuant this Agreement if such misrepresentation or falsification is made by the Billing Agency or Clearinghouse.

M. Should a misrepresentation or falsification occur of any record or other information essential to any claim submitted by the Provider to the Plan via the Billing Agency or

Clearinghouse, the Provider and Billing Agency or Clearinghouse agree that they shall be responsible for determining the responsible party for any misrepresentation or falsification.

N. The Provider and Billing Agency or Clearinghouse shall comply with the provisions of Title VI of the Civil Rights Act of 1964, as amended.

O. If it is determined by the Plan that the Billing Agency or Clearinghouse has violated any terms of this Agreement, it will not be authorized to act as Billing Agency or Clearinghouse for any Provider participating in the Plan's ESC program.

P. Provider specifically acknowledges that this Agreement does not make Provider a "Network Provider" or "Participating Provider" but is entered into only to allow ESC transmission.

II. ELIGIBILITY

The Provider and the Plan agree that the eligibility of a subscriber obtained through the System is only an indication of the subscriber's enrollment status and benefits at the time of inquiry. Plan payment of services is contingent upon the confirmation of status at the time of Plan claims processing and upon the terms and conditions of the subscriber's contract.

III. TRAINING

If the Provider is using software supplied by the Plan, the Plan agrees to provide a reasonable amount of training to Provider's personnel at the site of Plan's choice.

IV. TESTING

Testing of claims submissions may be required by the Plan prior to production acceptance of claims from the Provider. If testing is required, support will be provided by the Plan to the Provider or Billing Agency or Clearinghouse to attain a successful electronic transmission of claims, and to have at least ninety (90%) percent of the test claims accepted by the Plan's processing systems. The number of claims to be submitted for testing will be determined by the Plan based on the volume of electronic claims expected to be submitted by the Provider.

V. SUPPORT

A. The Plan agrees to supply the Provider, Billing Agency and/or Clearinghouse with a copy of the Plan's Companion Guide and Communication Specifications.

B. The Plan agrees to supply the Provider with a copy of the Plan's ESC Error Message manual with the understanding that this manual, in part or whole, is not to be transferred by any means to any other entity without written consent by the Plan.

C. The Plan agrees to supply the Provider, Billing Agency or Clearinghouse with free follow-up support as requested by the Provider.

VI. SYSTEM ACCESS

A. The Plan agrees to supply the Provider with a Submitter Identification number (Submitter ID) for ESC transmission. This Submitter ID is unique to each Provider and is not to be transferred by any means to any other entity without written consent by the Plan.

B. Transmissions will be accepted only during certain time periods which are to be designated by the Plan with the understanding that these periods may be altered by the Plan with prior notice given to the Provider.

VII. COST

A. Any and all costs incurred during the designing, implementation, etc., of the Provider's electronic submission of claims system will be the responsibility of the Provider.

B. Any and all telephone costs for access lines used by the Provider for ESC transmission will be the responsibility of the Provider.

VIII. DISCLAIMER OF WARRANTY

Plan makes no promises, warranties or representations concerning the ESC transmission process. Plan disclaims any and all express or implied representation and warranties with regard to the ESC transmission process, including any express or implied warranty of merchantability, fitness for a particular purpose, warranties concerning infringement, title, condition or the existence of any latent or patent defects, warranties arising from course of dealing, usage or trade practice, or warranties that the ESC transmission process will operate in an uninterrupted fashion or error free.

IX. FORCE MAJEURE

Plan shall not be responsible for delays or failures in performance resulting from acts or events beyond its reasonable control, including, but not limited to acts of nature, governmental actions, labor shortages, fire interruption of power supply, interruption of communications or natural disasters, however, Plan shall take reasonable efforts to minimize the effects of such acts or events.

X. ENTIRE AGREEMENT

This Agreement, including its attached Provider Identification Worksheet, shall constitute the entire Agreement between the Provider, the Plan and the Clearinghouse or Billing Agency as the case may be for the services and functions addressed in this Agreement, and may only be amended by a separate writing mutually agreed to by all parties. However, notwithstanding the foregoing, it is expressly agreed that any Participating Provider Agreement between the Plan and the Provider shall remain in full force and effect, separate and apart from the Agreement, and this Agreement shall not act to modify or alter the terms of that Agreement.

XI. CONTROLLING LAW

This Agreement shall be governed by the Laws of the State of Mississippi (without regard to conflict-of-law principles). ALL PARTIES CONSENT TO THE JURISDICTION AND VENUE OF THE FEDERAL AND STATE COURTS OF RANKIN COUNTY, MISSISSIPPI.

XII. TERMINATION

Any party may terminate this Agreement by giving thirty (30) days prior written notice to the other party.

THIS AGREEMENT is effective on or after acceptance of the Agreement by the Plan, which acceptance shall be evidenced by Plan affixing a date stamp on the Agreement and shall continue in full force and effect until termination with or without cause by either any party.

PROVIDER:

PROVIDER NAME

SIGNATURE

PRINTED NAME

DATE

BILLING AGENCY:

BILLING AGENCY NAME

SIGNATURE

PRINTED NAME

DATE

CLEARINGHOUSE:

Office Ally, Inc
CLEARINGHOUSE NAME

Cara Trahey
SIGNATURE

Cara Trahey
PRINTED NAME

02/19/24
DATE

Please return to:

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company
ATTN: EDI Services
3545 Lakeland Drive
Flowood, MS 39232
Fax: 601-936-5886

BlueCross BlueShield of Mississippi

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ELECTRONIC CLAIMS INFORMATION
Worksheet

PROVIDER INFORMATION (PLEASE PRINT)

Provider Name

Facility Name

Address

City, State, ZIP

Contact Name

Email Address

Telephone	Fax

IDENTIFICATION NUMBERS

TAX ID	Provider ID/NPI
Provider ID/NPI	Provider ID/NPI
Provider ID/NPI	Provider ID/NPI
Provider ID/NPI	Provider ID/NPI
Provider ID/NPI	Provider ID/NPI
Provider ID/NPI	Provider ID/NPI
Provider ID/NPI	Provider ID/NPI