BCBS DELEWARE PRE-ENROLLMENT INSTRUCTIONS – 00570

HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is 1 to 2 weeks.

WHERE SHOULD I SEND THE FORMS?

- Fax the form to (302) 421-2119; or
- Mail the original form to:
  Blue Cross Blue Shield of DE
  Attn: Electronic Claims (1-9-30)
  P.O. Box 1991
  Wilmington, DE 19899

PLEASE NOTE: PER BCBS DELEWARE EDI DEPARTMENT THE FORM CAN BE FAXED, DESPITE THE NOTATION ON THE FORM THAT IT MUST BE MAILED.

WHO CAN SIGN THE FORMS?

- The owner or authorized personnel

WHAT FORM SHOULD I DO?

- Electronic Data Exchange Enrollment

HOW DO I CHECK STATUS?

- You can call 800-842-5975 and ask if you have been linked to Office Ally's Submitter ID 330897513.

IT IS THE PROVIDERS RESPONSIBILTIY TO OBTAIN THE APPROVAL FROM BCBS DELEWARE AS THE PAYER DOES NOT RETURN ADEQUTE INFORMATION FOR OFFICE ALLY TO ENTER THE APPROVAL OR TO NOTIFY THE PROVIDER OF THE APPRVOAL.

NOTE TO MY CLIENTS PLUS USERS:

Once you have confirmed with the insurance payor that your provider number is linked to Office Ally, please fax the following information to My Clients Plus at 888-653-7115.

- **My Clients Plus**
- **Provider/Practice Name as pre-enrolled with the insurance payer**
- **Fed Tax ID**
- **Billing NPI**
- **Insurance Payer (including State if BCBS, Medicare or Medicaid).**
- **The statement "I have verified my provider ID has been linked to Office Ally with the Insurance Payor".**
- **Provider email address where you can be notified of setup completion.**

For Noridian Pre-Enrollments Please Also Include:

- **Submitter number**

Electronic Data Exchange Enrollment

Provider Name or Group

Provider Number

Address (street, city, state and zip code)

Contact Person

Telephone (include area code)

Adding to existing Submitter? ☐ Yes ☐ No. If "Yes,"

330897513

Submitter Number:

Office Ally

Name of (check one): ☐ Software Vendor ☐ Billing Service

P.O. Box 872020, Vancouver, WA 98687

Address (street, city, state and zip code)

Customer Service

Contact Person

866-575-4120 option 1

Telephone (include area code)

info@officeally.com

Email Address

In accordance with specifications set forth by Blue Cross Blue Shield of Delaware (The Corporation) for submission of automated claims, I / we agree that:

The Provider agrees to submit claims in accordance with the Participating Contract and in the format specified by The Corporation.

The Corporation agrees to accept and process claims submitted in accordance with this contract. Such processing and payment will be according to the terms of the Participating Provider Contract.

The Provider will ensure that every claim submitted can be readily associated and identified with the patient's medical and business office records. All medical records and source documents will be retained for a period of six (6) years after the month the bill was submitted. These records may be retained on microfilm.

The Provider agrees that the Corporation or its designee will have reasonable access to all documents pertaining to claims submitted via electronic media for the purpose of auditing and confirming the claims information submitted. Such access will be permitted to documents in the possession of the Provider, as well as the Provider's billing agent(s).

The Provider agrees that any overpayments which are discovered and brought to its attention will be refunded within thirty (30) days of the date of notification.

The Provider will research and correct any and all billing discrepancies caused by submission of automated claims.

The Provider /Corporation will maintain the confidentiality of passwords, preventing unauthorized users from committing data security violations with my log-on identification.

Signature of Health Care Professional or Authorized Representative

Title

Type or Print Name

Date

Please mail the signed original to:
Blue Cross Blue Shield of DE, Attn: Electronic Claims (1-9-30), P.O. Box 1991, Wilmington, DE 19899.

Blue Cross Blue Shield of Delaware is an independent licensee of the Blue Cross and Blue Shield Association.