

OFFICE ALLY

Avality Blue Cross Blue Shield of Florida Instructions

Attached is a template for a letter to link your provider number to Net HealthClaims Systems to send to Avality for Blue Cross Blue Shield of Florida. Office Ally connects to Avality through Net HealthClaims Systems for this payer.

Follow these instructions exactly:

- 1) Retype the attached letter on your physician or group letter head and have the provider or owner of the group sign.
- 2) Fax the letter to Avality at 904.470.2187
- 3) Call 800.282.4548 24 to 48 hours after faxing the letter to find out the status of the letter
- 4) Notify Office Ally after you receive confirmation from Avality that your provider number has been linked to submitter H7258 by filling in information below and faxing to Office Ally at 949.376.6951.
- 5) All fields listed below are required. Office Ally will notify you via email when we have received this form and entered the approval in our system. You must wait for the confirmation email from Office Ally before submitting claims electronically.

Office Ally Username: _ mcpadmin _____ Contact Name: _____

Contact Email: _____ Contact Phone: _____

Group Name: _____

Name of Provider	Group BCBS Provider No.	Individual BCBS Provider No.	Speciality	Tax ID
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

**You cannot submit claims electronically until you have received confirmation from
Avality that you are linked to submitter H7258
and
you have notified Office Ally of this confirmation
If you have questions, please contact Office Ally at 949.464.9129**

<Physician or Group Letterhead>

<This letter must be retyped on physician or group letterhead>

To: Availity

From: *[Physician or Group Name]*

[Physician or Group Address]

Tax ID #: *[Physician or Group Tax ID Number]*

Subject: Availity Provider Access Delegation Authorization Agreement

Date: *[Current Date]*

RE: Link my provider number to submitter H7258

I am currently under contract with ***Net HealthClaim Services, P.O. Box 455 Redlands, CA 92373 Submitter Number H7258*** for medical claims related services.

I do hereby authorize Net HealthClaim Services access to claims and eligibility data for my patients through their use of the Availity Gateway. I do hereby affirm that all of the necessary consents have been obtained from such patients to grant access to their claims and eligibility data to *Net HealthClaim Services*.

Upon the termination of services provided by Net HealthClaim Services to my practice, I understand it is my responsibility to notify Availity through the execution of the Availity Termination of Provider Access Delegation Form which can be provided by the Business Associate currently performing transactions on my behalf or accessed online at www.availity.com.

[Physician or Group Name]

[Title]

Signature

Date