

CAHABA GBA (PART A – RURAL MEDICARE) PRE-ENROLLMENT INSTRUCTIONS – 10301



Cahaba GBA has changed their enrollment process. They now require all enrollments to be completed online. Each form is accompanied by a fax cover sheet with a unique barcode which **MUST** accompany the form when submitted via fax to Cahaba GBA.

HOW LONG DOES PRE-ENROLLMENT TAKE?

- It takes approximately 10 business days to complete the enrollment process. Cahaba GBA will notify the provider. Office Ally does not receive notification of new enrollments. It is up to the provider to contact Office Ally once they are approved.

WHERE SHOULD I SEND THE FORM?

- Fax the form to Cahaba EDI at (205) 402-5706

HOW DO I ENROLL / WHAT FORM DO I COMPLETE?

- Open your internet browser and go to:
http://www.cahabagba.com/part_a/forms/PartAApplication.pdf
- Complete the EDI Services Part A Enrollment Application as instructed below:

General Information: Complete with information provided below

State: Alabama Georgia Tennessee Rural Health Clinic Home Health & Hospice

I am a (Select one):

Facility Information: Complete with Facility information

Facility Name:

Mailing/Pay-To Address:

City: State: Zip Code:

Contact Name: E-Mail Address:

Phone Number: Fax Number:

Medicare Facility number (PTAN) Facility NPI Facility EIN

List additional Medicare Facility number(s) (PTANs)

List additional NPI(s)

List additional EIN(s)

Data Interchange Information-Claims: Complete with information provided below

I will be sending my claims:

Submitter ID (If using an existing ID or a Billing Service/Clearinghouse indicate Submitter ID here):

Data Interchange Information-Remittance Advice: Complete with information provided below

I will be retrieving my remittance advice notices:

Submitter ID for ERA Retrieval (If left blank a new ID will be assigned)

Using a Billing Service/Clearing House (3rd Party) Complete with information provided below

Billing Service/Clearinghouse Name:

Mailing Address: Phone Number:

City: State: Zip Code:

Contact Name: E-Mail Address:

Will this Billing Service/Clearinghouse be accessing FISS on your behalf to key claims into the DDE system, correct claims in FISS, verify patient eligibility and/or verify claim status? (Checking YES indicates you are authorizing the indicated agency to have FISS access for the provider numbers listed on this application) Y N

Using software from a vendor SKIP

Software Vendor Name:

Mailing Address: Phone Number:

City: State: Zip Code:

Contact Name: E-Mail Address:

Data Interchange Information-276/277 (Batch Claim Status Requests): SKIP

I will be sending/retrieving my 276/277 files:

Submitter ID for 276/277 Transactions:

Connectivity Information: SKIP

IVANs Vision Share Other:

[Read Page 4 – Cahaba GBA Agreement](#)

Signature: (By signing this document you are stating that you are authorized to sign on behalf of the indicated party and have read and agree to the foregoing provisions and acknowledge Complete this section with provider/facility information

Name: Title

Mailing Address:

City: State: Zip Code:

Signature: _____ Date

3. Print the entire form, including the cover sheet (page 1). Sign where requested & fax the form the Cahaba GBA EDI Department at (205) 402-5706. You MUST include the cover sheet provided by Cahaba GBA with this submission or your application will be denied.

HOW DO I CHECK STATUS?

- Call 866-582-3253 and ask if your provider number has been linked to Office Ally. If it has been linked you MUST notify My Clients Plus.

WHAT PROVIDER NUMBER DO I USE?

- Medicare PTAN Group Number
- User one (1) provider number per form
- If you are a group, list only your group name and group number. Do one form for each group number you have.

NOTE TO MY CLIENTS PLUS USERS:

Once you have confirmed with the insurance payor that your provider number is linked to Office Ally, rather than contact Office Ally as directed above, 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**