WELCOME TO OFFICE ALLY!

MEDICARE GEORGIA PRE-ENROLLMENT INSTRUCTIONS

HOW LONG DOES PRE-ENROLLMENT TAKE?

- It takes approximately 10 business days to complete the enrollment process, Medicare GA then notifies the provider. Office Ally does not receive notification of new enrollments from Medicare GA. It is up to the provider to contact Office Ally once they are approved.

WHERE SHOULD I SEND THE FORMS?

- Mail the original forms to Office Ally
  - We request that you mail the forms to Office Ally, so that we can review the forms and make a note of your provider number and the date the form was mailed to Medicare.
- You may also mail to Cahaba GBA P.O. Box 3018, Savannah, GA 31402
- Forms may also be faxed to 205-220-9116

WHO CAN SIGN THE FORMS?

- Forms must be signed by the provider (if the form is for a solo doctor) or the president, CEO, or owner of the group (if the form is for a group).

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 at 877-525-1169 PRIOR to submitting claims.

WHAT PROVIDER NUMBER DO I USE?

- Medicare PTAN Group Number
- Use 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.

*32356 S. Coast Highway * Laguna Beach CA * 92651 Phone: 949.464.9129 Fax: 949.376.6951*
www.officeally.com

CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC

Medicare Part B

ELECTRONIC DATA INTERCHANGE (EDI) APPLICATION

A SELECT STATE (Select One)

☐ALABAMA ☐GEORGIA ☐MISSISSIPPI

B NAME OF GROUP, PHYSICIAN, OR FACILITY

C MAILING ADDRESS

ADDRESS ______________________________

CITY ______________________ STATE ____________ ZIP CODE ____________

D CONTACT PERSON	**E** TELEPHONE NUMBER

F FAX NUMBER	**G** E-MAIL ADDRESS

H MEDICARE GROUP OR PROVIDER NUMBER	**I** NATIONAL PROVIDER IDENTIFIER	**J** FEDERAL ID TAX NUMBER

K SOFTWARE VENDOR, BILLING SERVICE, OR CLEARINGHOUSE INFORMATION

REQUESTING MEDICARE'S FREE PC-ACE PRO32 SOFTWARE (If yes, go to section **L**) ☐ YES X NO

METHOD OF DATA INTERCHANGE (Select one) ☐ SOFTWARE VENDOR (DIRECT) X BS/CLEARINGHOUSE (3rd PARTY)

NAME ___Office Ally, LLC___________________________ PHONE NUMBER ___949.464.9129______________________

STREET ADDRESS __32356 S. Coast Highway____

CITY __Laguna Beach ______________________________ STATE ___CA___________ ZIP CODE ____92651_______________

SUBMITTER ID (If known) ____GAF01-723_______________

L REQUESTING ELECTRONIC REMITTANCE ADVICE (See important note concerning ERA located on instruction page.)

☐ YES ☐ NO

M If the method of data interchange selected above is billing service or clearinghouse, you authorize the entity listed in section **K** to conduct electronic transactions on your behalf. A provider may not authorize submission or receipt of Medicare beneficiary information by a third party unless that beneficiary is a current patient of the provider, has scheduled an appointment, or has inquired about the receipt of supplies or services from the provider.

I have read and agree to the above statements and foregoing provisions contained within the attached EDI Enrollment Form.

Authorized Signature	Printed Name
Title	Date

EDI ENROLLMENT FORM MUST BE SUBMITTED WITH THIS APPLICATION