

PREMERA BLUE CROSS BLUE SHIELD OF ALASKA PRE-ENROLLMENT INSTRUCTIONS – BC099



HOW LONG DOES PRE-ENROLLMENT TAKE?

- Approximately 5 business days

WHERE SHOULD I SEND THE FORMS?

- Fax the form to 425-918-4234 or;
- Mail the form to:
Premera Blue Cross
PO Box 327
M/S 481
Seattle, WA 98111-0327

WHO CAN SIGN THE FORMS?

- No signature is required

WHAT FORM SHOULD I DO?

- EDI Trading Partner Information

HOW DO I CHECK STATUS?

- You will receive an email from Office Ally notifying you of your approval once the form has been processed and approved. Once you receive this email you can begin submitting claims for electronic transmission.
- You can also call 800-435-2715 ext. 3 and ask if you have been approved.

WHAT PROVIDER NUMBER DO I USE?

- Tax ID
- NPI

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**



BLUE CROSS

EDI Trading Partner Information

Premera Blue Cross
PO Box 327
M/S 481
Seattle, WA 98111-0327

Phone: 800-435-2715
Fax: 425-918-4234
e-mail: edi@premera.com

Enrollment is required to establish the process of exchanging electronic HIPAA transactions between Premera Blue Cross and Office Ally. Please complete the following information and return to the above address, email or fax number. This form must be completed in full.

1. Trading Partner Demographics:

Provider or Group/Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Title: _____

Phone: _____ Fax: _____ Email Address: _____

Tax ID: _____ National Provider Identifier (NPI) _____

Type of Claims Professional Institutional

Health Plan: Premera ___ LWHP of OR ___ LWHP of AZ ___

Clearinghouse Name: Office Ally _____