

US DEPARTMENT OF LABOR PRE-ENROLLMENT INSTRUCTIONS - 77044



HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is 14 business days.

WHERE SHOULD I SEND THE FORMS?

- Fax the form to (850) 201-1718; or
- Mail the form to:
ACS Enrollment Department
PO Box 14600
Tallahassee, FL 32317-4600

WHO CAN SIGN THE FORMS?

- The owner or authorized agent.

WHAT FORM SHOULD I DO?

- Department of Labor – OWCP Electronic Data Interchange

HOW DO I CHECK STATUS?

- You can call 1-866-335-8319 and ask if you have been linked to Office Ally's Submitter ID 164851.

WHAT PROVIDER NUMBER DO I USE?

- Tax ID

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**



**Department of Labor-OWCP
ELECTRONIC DATA INTERCHANGE**



PLEASE INDICATE YOUR CLASSIFICATION:

Software Vend
 Switch Vend
 Provider
 Clearinghouse
 Billing Agent

A1. Please indication classification information.			
Submitter/Vendor/Provider Name:			
Address:			
City, State, Zip:			
Telephone #:		FAX #:	
Provider Number:		EIN:	
Group Provider Number:		EMAIL ADDRESS:	
Provider Specialty:			
A2. Please indicate contact information, if different from Submitter/Vendor/Provider Information in Section A1.			
Contact Name and Title:			
Business Address:			
City, State, Zip:			
Phone Number:		Fax Number:	
Email Address:			
A3. If you have indicated that you are a Software Vendor in section A1, please provide the following information:			
Software Name:		Software Version:	Protocol:
Do you currently have clients submitting to ACS? <input type="checkbox"/> Yes <input type="checkbox"/> No			
A4. Electronic Submission Method			
Submitter Type:	<input type="checkbox"/> Vendor Software	<input checked="" type="checkbox"/> Clearinghouse	<input type="checkbox"/> Billing Agent Office Ally Sub. ID 164851
Format Type:	<input type="checkbox"/> Proprietary	<input checked="" type="checkbox"/> X12N	
Transaction Type:	<input checked="" type="checkbox"/> Professional	<input type="checkbox"/> Dental	<input type="checkbox"/> Institutional <input checked="" type="checkbox"/> HCFA <input type="checkbox"/> UB
Submission Method:	<input type="checkbox"/> WEB	<input type="checkbox"/> NDM	<input checked="" type="checkbox"/> ASYNC
A5. Electronic Report Retrieval			
Are you interested in retrieving your transaction electronically? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Who will retrieve your reports? <input type="checkbox"/> You <input type="checkbox"/> Billing Agent <input checked="" type="checkbox"/> Clearinghouse			
Which reports would you like to access electronically? <input checked="" type="checkbox"/> Functional Acknowledgement (997) <input checked="" type="checkbox"/> Healthcare Claim Payment Advice (835)			

Please return complete forms via Mail or FAX to: (850) 201-1718
ACS ENROLLMENT DEPARTMENT PO Box 14600, Tallahassee FL. 32317-4600

(Incomplete forms will cause a delay in processing and are subject to return).