BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

EDI Enrollment Request for *EXISTING* Submitter ID

Existing Submitter ID: _____

Section I.

PRACTICE/FACILITY NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

Section II.

VENDOR/CLEARINGHOUSE NAME:_____

CONTACT NAME:_____BLUE CROSS VENDOR ID:_____

Section III.

Indicate the requested transaction(s): ☐ 837 – claim (batch)
☐ 270/276/278 –eligibility, claim status, and referral (real-time)

Section IV. *(Continue provider list onto page 2 if additional space is needed.)*

NAME OF PROVIDER	PROVIDER NPI	TAX ID

Blue Cross will assign provider passwords and forward to the vendor.

Completed form(s) should be faxed to EDI Services at 205 733-7362 or emailed to EDIEnrollment@bcbsal.org.

The undersigned hereby:

- Represents and warrants that he or she has full power and authority to execute this agreement on behalf of the health care provider identified in Section I (Provider) and to bind the Provider to the terms and conditions of this agreement;
- Authorizes Blue Cross and Blue Shield of Alabama (BCBSAL) (1) to disclose protected health information to the business associate identified in Section II (Business Associate); and (2) to return Provider passwords to Business Associate;
- Agrees to notify BCBSAL if the Business Associate changes;
- Agrees that Provider will be responsible for all electronic transactions submitted to BCBSAL by Provider, its employees, and its agents;
- Agrees that BCBSAL has the right to audit and confirm information submitted by or on behalf of Provider and shall have access to all original source documents and medical records related to Provider's submissions. All incorrect payments shall be adjusted in accordance with BCBSAL guidelines;
- Agrees that Provider will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all data from improper access; and
- Agrees to establish and maintain procedures and controls so that information concerning Blue Cross subscribers, or any information obtained from Blue Cross, shall not be used by agents, officers, or employees of the billing service except as provided by Blue Cross.

_____ _____

Authorized Representative of Provider Date

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EDI Enrollment Request
Additional Providers

This **optional** form must be accompanied by page 1 of a ***New*** or ***Existing Submitter ID*** form.

Submitter ID: _____

NAME OF PROVIDER(S)	PROVIDER NPI	TAX ID

The undersigned hereby:

- Represents and warrants that he or she has full power and authority to execute this agreement on behalf of the health care provider identified in Section I (Provider) and to bind the Provider to the terms and conditions of this agreement;
- Authorizes Blue Cross and Blue Shield of Alabama (BCBSAL) (1) to disclose protected health information to the business associate identified in Section II (Business Associate); and (2) to return Provider passwords to Business Associate;
- Agrees to notify BCBSAL if the Business Associate changes;
- Agrees that Provider will be responsible for all electronic transactions submitted to BCBSAL by Provider, its employees, and its agents;
- Agrees that BCBSAL has the right to audit and confirm information submitted by or on behalf of Provider and shall have access to all original source documents and medical records related to Provider's submissions. All incorrect payments shall be adjusted in accordance with BCBSAL guidelines;
- Agrees that Provider will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all data from improper access; and
- Agrees to establish and maintain procedures and controls so that information concerning Blue Cross subscribers, or any information obtained from Blue Cross, shall not be used by agents, officers, or employees of the billing service except as provided by Blue Cross.

_____ _____

Authorized Representative of Provider Date