



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

Section I.

PRACTICE/FACILITY NAME: _____		
ADDRESS: _____		
CITY: _____	STATE: _____	ZIP: _____

Section II.

VENDOR/CLEARINGHOUSE NAME: _____	
CONTACT NAME: _____	BLUE CROSS VENDOR ID: _____

Section III.

<u>Required Information</u>	<u>Optional Information</u>
Indicate the requested transaction(s): <input type="checkbox"/> 837 – claim (batch) <input type="checkbox"/> 270/276/278 – eligibility, claim status, and referral (real-time) Indicate submitter ID: <input style="width: 150px; height: 20px;" type="text"/>	Indicate the FTP directory where audit reports should be delivered <u>if different than submitter ID</u> : <input style="width: 150px; height: 20px;" type="text"/> <input type="checkbox"/> Check here if a dial-up connection is needed. <i>NOTE: A dial-up connection is not required if the FTP server is accessed through the internet or a frame relay connection.</i>

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

