# BCBS Of Mississippi EDI ERA Enrollment

**Submit the completed Payer Request Form to:**
Inovalon Enrollment
enrollmentsupport@inovalon.com

## INSTRUCTIONS

- Complete all sections of the **Payer Request Form**
- Complete this form using group or individual provider information as listed on file with the payer you wish to set up

**Note:** Some payers require additional documentation to be completed and signed by the provider in order to complete enrollment. If additional forms are required, the required forms will be sent to you for completion.

**IMPORTANT: You must specify the payer(s) with which you wish to enroll. If no payers are specified, enrollment forms WILL BE RETURNED.**

If you have more than ten payers to enroll, please make additional copies of this form.

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enrollmentsupport@inovalon.com

## INSTRUCTIONS

Complete one form per TAX ID.

## PROVIDER BILLING INFORMATION

*Please type your responses directly into the form.*

Please check: ☐ New Request ☐ Change Request

Billing Service Name (if applicable)

TIN or INOVALON ID: MD Online, Inc.

Contact Name:

Phone: ( ) Fax: ( ) Email:

Group/Provider Name:

Please check for designation: ☐ Professional ☐ Institutional

Billing Tax ID: Indicate ☐ TIN/EIN ☐ SSN Billing NPI:

Street Address:

City: State: Zip:

Name of Authorized Signee:

Title of Authorized Signee:

## PAYER INFORMATION

*List payers with which you wish to enroll below. Please refer to the Inovalon Payer List for enrollment requirements. Check the transaction(s) you want to enroll for each payer.*

| Payer ID | Payer Name | PTAN, Medicaid ID or Provider ID | Claims | ERA |
|---|---|---|---|---|
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Inovalon Enrollment
enrollmentsupport@inovalon.com

## INSTRUCTIONS

- Print these instructions. Refer to them as you complete the registration process.
- **IMPORTANT: You must indicate on the attached setup form whether you would like to receive ERA. Providers must be set up to submit claims before Inovalon can set up ERA.**
- Please type provider information on the forms for ease of processing at Inovalon.
- Page 1: Agreement Between BCBS MS, Clearinghouse, and Provider:
  - Enter the date and group or provider name.
  - You are advised to read through the terms of this agreement. There are no fields to complete until Page 5.
- Page 5: Provider:
  - On the left-hand side, complete the group/provider name.
  - Complete the name of the person authorized to sign this form.
  - **After printing, sign and date on the left-hand side of this form.**
- Page 6: Electronic Claims Information Worksheet:
  - Enter the individual or group provider information requested on the top half of the form.
  - If you are a group provider, complete the bottom of this form with the rendering provider names and NPIs in the group as requested on the form.
  - Do not alter prefilled clearinghouse information.

BlueCross BlueShield of Mississippi

It's good to be Blue.

BLUE CROSS & BLUE SHIELD OF MISSISSIPPI,
A MUTUAL INSURANCE COMPANY

# ELECTRONIC SUBMISSION OF CLAIMS AGREEMENT

THIS AGREEMENT is by and between BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, A Mutual Insurance Company ("Plan") and

_____, ("Provider").

IN CONSIDERATION of authorizing the Provider to submit claims for healthcare services electronically through the system referred to as Electronic Submission of Claims ("ESC"), the parties agree to adhere to the mutual promises and conditions set forth in the following sections.

I. The Provider certifies and specifically agrees:

A. The Provider shall comply with all applicable state and federal laws and regulations, including but not limited to, the requirements of the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. Part 160, Part 162 and Part 164) and the Social Security Act §1173 and all implementing regulations, as may be amended or recodified from time to time, Plan's companion guide, and any and all Plan communication and submission specifications and requirements. Plan may reject any non-conforming transaction/submission.

B. The Provider shall implement appropriate safeguards to prevent unauthorized access to its transmission and processing systems and transactions with the Plan. Such safeguards will include steps to prevent persons with authorized access from exceeding the scope of their access.

C. Authorization for payment to the Provider and for release of medical information has been fully executed by the patient. The required patient signature, or where applicable, appropriate signatures on behalf of patients, and required physician certification/recertification, where applicable, are on file and will be maintained by the Provider for six (6) years, or the time period required by applicable law, whichever is longer.

D. Source documents will be maintained by the Provider for not less than six (6) years from the claim submission date. Provider agrees the Plan, or its designees, have the right to audit and confirm any information submitted. Any incorrect payments which are discovered as a result of such an audit will be adjusted according to applicable provisions of the Social Security Act as amended, regulations, guidelines, provisions contained in the Plan's contracts, and Plan policy guidelines. The provisions of this Section I(D) shall survive termination of this Agreement.

E. In the event a billing agency and/or clearinghouse is authorized by the Provider to submit electronic claims on the Provider's behalf, a written contract will be secured between the Provider and the billing agency and/or clearinghouse detailing the billing agency's and/or clearinghouse's responsibilities to report information as directed by the Provider. A copy of the contract will be furnished to the Plan, if requested. Both the Provider and the billing agency and/or clearinghouse must maintain a record of all electronic claims submitted for payment for six (6) years from the claim submission date, or the time period required by

applicable law, whichever is longer.

F. Should the provider engage the services of a billing agency and not a clearinghouse, the Provider agrees it is the Provider's obligation, along with the billing agency, to research and correct any and all billing discrepancies caused by either of them and to hold the Plan harmless for any costs or expenses, including claims overpayments or other damages incurred as a result of such billing discrepancies.

G. In the event the Provider discontinues its relationship with any billing agency and/or clearinghouse, the Provider will notify the Plan immediately and will supply the successor billing agency's and/or clearinghouse's name, address and contact personnel.

H. The Provider agrees to indemnify, defend and hold the Plan harmless from any and all claims, actions, damages, liabilities, costs, or expenses, including, without limitation, reasonable attorneys' fees, arising out of any act or omission of the Provider or its employees, subcontractors or agents in the performance of this Agreement. The Plan will have the option at its sole discretion to employ attorneys to defend any such claim, action or proceeding arising out of these acts or omissions, the costs and expenses of which will be the Provider's responsibility. The Provider will provide information, documents and other cooperation as reasonably necessary to assist the Plan in establishing its defenses to such action, at no cost to the Plan.

I. The Provider will comply with all applicable statutes, regulations, and healthcare industry guidelines/customs concerning treatment of confidential and/or proprietary information. The Provider will treat Plan's confidential and/or proprietary information as confidential and will not use Plan's confidential and/or proprietary information for any purpose not authorized by this Agreement. The Provider shall limit use and access of confidential and/or proprietary information to the Provider's employees and agents who have a need to know such information and shall ensure such employees and agents maintain the confidentiality of such information. The provisions of this Section I(I) shall survive termination of this Agreement.

J. The Provider agrees the submission of an electronic claim is a claim for payment and assumes sole liability for misrepresentation or falsification of any record or other information essential to that claim or that is required pursuant to this Agreement if such misrepresentation or falsification is made by the Provider.

K. Should a misrepresentation or falsification occur of any record or other information essential to any claim submitted by the Provider to the Plan via the billing agency and/or clearinghouse, the Provider agrees that it, along with the billing agency and/or clearinghouse, shall be responsible for determining the responsible party for any misrepresentation or falsification.

L. Provider specifically acknowledges this Agreement does not make Provider a "Network Provider" or "Participating Provider", but is entered into only to allow ESC transmission.

M. The Provider shall require its employees, subcontractors and agents to comply with the terms of this Agreement.

## II. ELIGIBILITY

The Provider and the Plan agree any eligibility of a subscriber obtained through the system is only an indication of the subscriber's enrollment status and benefits at the time of inquiry. Plan payment of services is contingent upon the confirmation of status at the time of Plan claims processing and upon the terms and conditions of the subscriber's contract.

## III. TRAINING

If the Provider is using software supplied by the Plan, the Plan agrees to provide sufficient training to Provider's personnel at the site of Plan's choice.

## IV. TESTING

Testing of claims submissions may be required by the Plan prior to production acceptance of claims from the Provider. If testing is required, support will be provided by the Plan to the Provider or the Provider's billing agency and/or clearinghouse to attain a successful electronic transmission of claims, and to have at least ninety (90%) percent of the test claims accepted by the Plan's processing systems. The number of claims to be submitted for testing will be determined by the Plan based on the volume of electronic claims expected to be submitted by the Provider.

## V. SUPPORT

A. The Plan agrees to supply the Provider with the Plan's companion guide, communication specifications and ESC Error Message manual, with the understanding this manual, in part or whole, is not to be transferred by any means to any other entity without written consent by the Plan.

B. The Plan agrees to supply the Provider with support as requested by the Provider.

## VI. SYSTEM ACCESS

A. The Plan agrees to supply the Provider with a Submitter Identification number (Submitter ID) for ESC transmission, if applicable. This Submitter ID is unique to each Provider and is not to be transferred by any means to any other entity without written consent by the Plan. The Provider shall protect and maintain the confidentiality of any submitter ID, username and/or password issued to the Provider by the Plan.

B. Transmissions will be accepted only during certain time periods which are to be designated by the Plan with the understanding these periods may be altered by the Plan with prior notice given to the Provider.

## VII. COST

The Provider is responsible for all costs, expenses, charges, or fees the Provider may incur in transmitting electronic transactions to, or receiving electronic transactions from, the Plan. Plan shall have no liability for any such costs, expenses, charges or fees.

## VIII. TERMINATION

Either party may terminate this Agreement by giving thirty (30) days prior written notice to the other party. If it is determined by the Plan that the Provider has violated any term of this Agreement, Plan may terminate this Agreement immediately.

## IX. DISCLAIMER OF WARRANTY

Plan makes no promises, warranties or representations concerning the ESC transmission process. Plan disclaims any and all express or implied representation and warranties with regard to the ESC transmission process, including any express or implied warranty of merchantability, fitness for a particular purpose, warranties concerning infringement, title, condition or the existence of any latent or patent defects, warranties arising from course of dealing, usage or trade practice, or warranties that the ESC transmission process will operate in an uninterrupted fashion or error free.

## X. FORCE MAJEURE

Neither Plan nor Provider shall be responsible for any delay or failure in performance caused by flood, riot, looting, insurrection, fire, earthquake, hurricane, tornado, communication line failure, power line failure, explosion, act of God, pandemic, epidemic, or any other force or cause beyond the reasonable control of the party claiming the protection of this Section. If any of the above enumerated circumstances prevent, hinder or delay performance of Provider's or Plan's obligations for more than thirty (30) calendar days, the party not prevented from performing may, at its option, terminate this Agreement without liability or penalty as of the date specified by such party in a written notice of termination to the other party. The Plan and the Provider acknowledge and agree that labor shortages, disputes and strikes shall not be considered a force majeure event.

## XI. MISCELLANEOUS

(1) Plan may amend this agreement at any time for any reason by giving the Provider sixty (60) days prior written notice.

(2) No termination of this Agreement will affect the rights and obligations of the parties to this Agreement that have accrued under this Agreement prior to the effective date of termination.

(3) Plan reserves the right to the control and use of its name, symbols, trademarks, trade names, service marks, and copyrights presently existing or later established. The Provider shall not use Plan's name, symbols, trademarks, trade names, or service marks in advertising, promotional materials, publications, interviews, or otherwise, without the prior written consent of Plan. Plan hereby consents for the Provider to use its name in non-promotional publications such as annual reports or SEC filings. Any permitted use shall terminate upon termination of such consent or upon termination of this Agreement, which ever first occurs.

(4) This Agreement shall be governed by the laws of the State of Mississippi (without regard to conflict-of-law principles). The Provider consents to the jurisdiction and venue of the federal and state courts of Rankin County, Mississippi.

(5) The Provider may not assign this Agreement without the consent of Plan. This Agreement shall be binding upon and insure to the benefit of the parties hereto and their respective successors and assigns.

(6) The terms of this Agreement may be waived only by a written instrument expressly waiving such term or terms and executed by the party waiving compliance. The waiver of any term or condition of this Agreement by either party hereto shall not constitute a modification of this Agreement, nor prevent a party hereto from enforcing such term or condition in the future with respect to any subsequent event, nor shall it act as a waiver of any other right accruing to such party hereunder.

(7) This Agreement is divisible and separable. If any provision of this Agreement is held to be or becomes invalid, illegal, or unenforceable, such provision or provisions shall be reformed to approximate as nearly as possible the intent of the parties, and the remainder of this Agreement shall not be affected thereby and shall remain valid and enforceable to the greatest extent permitted by law.

(8) With the exception of the Provider's breach of Section 1(B), 1(I) and/or VI(A), neither the Plan nor the Provider will be liable for any special, incidental, indirect, exemplary or consequential damages resulting from any claim or cause of action arising out of any delay, omission or error in any electronic claim submission or the other party's performance or failure to perform in accordance with the terms of this Agreement, including, without limitation, loss of use, revenues, profits or savings, even if a party has been advised in advance of the possibility of such damages.

THIS AGREEMENT is effective upon acceptance of the Agreement by Plan, which acceptance shall be evidenced by Plan's approval and implementation of the Provider's ability to submit claims electronically directly to Plan or through Provider's designated clearinghouse and/or billing agency, if applicable, and shall continue in full force and effect until termination with or without cause by either any party.

_____
PROVIDER NAME

_____
SIGNATURE

_____
PRINTED NAME

_____
DATE

BlueCross BlueShield of Mississippi

It's good to be Blue.

# ELECTRONIC CLAIMS INFORMATION
# Worksheet

| PROVIDER INFORMATION (PLEASE PRINT) | |
|---|---|
| Provider Name | |
| Facility Name | |
| Address | |
| City, State, ZIP | |
| Contact Name | |
| Email Address | |
| Telephone | Fax |

| IDENTIFICATION NUMBERS | |
|---|---|
| TAX ID | Provider ID/NPI |
| Provider ID/NPI | Provider ID/NPI |
| Provider ID/NPI | Provider ID/NPI |
| Provider ID/NPI | Provider ID/NPI |
| Provider ID/NPI | Provider ID/NPI |
| Provider ID/NPI | Provider ID/NPI |
| Provider ID/NPI | Provider ID/NPI |

CLEARINGHOUSE NAME:

MD Online, Inc.

I agree to be set up to receive Electronic Remittance Advices (ERAs):

YES [X] NO [ ]