



## 835 Health Care Electronic Remittance Advice (ERA) Request Form

This form enables providers or other entities to request a HIPAA X12N 835 version 4010A1 electronic remittance advice transaction from Blue Cross and Blue Shield of Florida (BCBSF) through the Availity<sup>®1</sup> Health Information Network. It may also be used to add/remove providers or update existing information.

**Note:** Providers must register their National Provider Identifier (NPI) with BCBSF prior to submitting this request form. The form is available on our website, [www.bcbsfl.com](http://www.bcbsfl.com), under the Physician & Providers section, Tools & Resources and then Forms.

### Completion Instructions

**Letter of Intent (LOI)** - If your Tax Identification (ID) number is currently set up to receive 835 remittance files under a vendor<sup>2</sup> and you would like to change vendors, then an LOI is required. An LOI is a notification from the provider on office letterhead requesting a change. The name of the current vendor, name of the new vendor and the responsible party's signature must be included in the LOI.

#### **Section A: Type of Request**

- **Initial Request** – Check to receive an 835 Health Care ERA as a new receiver.
- **Provider Change** – Check to modify existing information, such as name, Tax ID or add/delete a provider.

#### **Section B: Trading Partner Organization Information**

Complete the trading partner organization information. All fields must be completed.

#### **Section C: Provider/Facility Numbers**

- **C1: Professional Association (PA) Group**  
Complete this section if you are a professional group. Only list the group name, BCBSF group provider number, group Tax ID number and group NPI number.
- **C2: Professional Solo Practice**  
Complete this section if you are a professional solo practice (individual provider, laboratory, DME supplier, etc.).
- **C3: Facility/Institution**  
Complete this section if you are a facility/institution.

#### **Section D: Availity Provider Access Delegation**

Complete this section if you are a provider who contracts with a Business Associate authorized to access claims and eligibility data for your patients through the Availity Gateway.

### Availity Information

All HIPAA X12N 835 version 4010 A1 Health Care ERA receivers must be registered with Availity prior to submitting this request form. To register with Availity, please call **(800) AVAILITY (282-4548)** or visit their website at [www.availity.com](http://www.availity.com).

<sup>1</sup>Availity, L.L.C., is a multi-payer joint venture company. For more information or to register, visit Availity's website at [www.availity.com](http://www.availity.com).

<sup>2</sup>A vendor is defined as a billing service, clearinghouse or hardware/software support company who receives electronic remittances on behalf of BCBSF providers



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**Processing Timeframe:** Upon receipt, this form will be processed within 2-3 business days. Once the setup is complete, the 835-remittance generation will be dependent on the next payment cycle that the specified provider's claims process on. Please ensure all information is complete and the Letter of Intent is attached, if necessary to avoid a return for additional information. (See completion instructions)

**Note:** If you do not access your 835 Electronic Remittance Advices for sixty (60) days, then your access will be removed and you will have to register again to be granted access.

### Section A: Type of Request

Initial Request                       Provider Change:  Add    Update    Remove

### Section B: Trading Partner Organization Information (Example: Billing Provider, Billing Service, or Clearinghouse)

★ **Required Fields**

If unknown, contact (800) AVAILITY (282-4548)

- ★ **Availity Genkey:** \_\_\_\_\_  
Also known as the Org ID
- ★ **BCBSF Sender ID:** \_\_\_\_\_  
5-digit ID starting with G or H, Example: GB102, H0051

★ Organization/Sender Name: \_\_\_\_\_

Organization Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

★ Contact Name (printed): \_\_\_\_\_

★ Contact Signature: \_\_\_\_\_

★ Email Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

### Section C1: Professional Association (PA) Group

Professional Association (PA) Group Name	BCBSF Group Provider Number	Group Federal Tax ID	Group National Provider Identifier (NPI)

### Section C2: Professional Solo Practice

Professional Solo Practice Name	BCBSF Provider Number	Federal Tax ID	National Provider Identifier (NPI)

### Section C3: Facility/Institution

Facility/Institution Name	BCBSF Provider Number	Federal Tax ID	National Provider Identifier (NPI)

If additional space is required, please copy this page.