



Capario Enrollment
1901 E. Alton Ave. #100
Santa Ana, CA. 92705
Phone: (800) 792-5256 Option 1
Fax: (404) 877- 3324
provider.enrollment@Capario.com

ERA Payer Agreement Instructions for New York Blue Cross Blue Shield – Rochester (BS061)

To enroll with this payer for ERA complete and send the payer agreement directly to Capario. In addition please complete and send the Capario ERA Enrollment Request Form to our EDI Team. Specific instructions for this Payer are shown below.

ERA Transactions are available as an additional Capario contracted service. To add ERAs to your contract please contact your Capario Sales Representative or Account Manager. ERA must be part of your contract and you must be enrolled with this Payer BEFORE submitting this ERA Payer Agreement.

EFT enrollment and transmission is an arrangement between the provider and the Payer. If the Payer offers EFT transactions contact them to determine if they:

- Require you to receive EFT in order to receive their ERAs
- Charge an additional fee for EFT/ERA
- Require you to enroll for EFT on this ERA enrollment form.

Guidelines for Enrolling with this Payer

For this payer, the Schedule CR to consent to receive Electronic Remits – Agent Addendum must be completed, signed and mailed to Capario.

- Section 6: Signatures (Required)
 - Physician (s) Section: This agreement must be signed with the original signature of the physician. Stamped signatures will not be accepted.
 - Agent’s Name (s): Leave blank and do not sign. Reserved for signature by our EDI Team.
- Billing Service or Clearinghouse Representative: Pre-Filled
- Physician (s): Complete this section
- Physician (s) Signature: Sign with original signature. Stamp signatures are not allowed

1. Mail the Schedule CR to Consent to Receive ERA and Capario ERA Enrollment Request Form to:

Fax: (404) 877-3324
EDI Team
Capario
1901 E. Alton Ave. Suite 100
Santa Ana, CA. 92705

To obtain the Capario ERA Enrollment Request Form, go to:
www.capario.com/services/resource_center/enrollment_instructions.html

Questions? Contact Capario Enrollment at: (800) 792-5256 Option 1



Payor Agreement Cover Sheet

Agreement Type: Remittance

Estimated Approval Time: 14 days from RelayHealth's receipt of agreement

Multiple Clearinghouses: No

<input type="checkbox"/> CPID 3449	NEW YORK BLUE SHIELD CENTRAL REGION - Professional
<input checked="" type="checkbox"/> CPID 4408	NEW YORK BLUE SHIELD OF ROCHESTER - Professional
<input type="checkbox"/> CPID 7432	NEW YORK BLUE SHIELD UTICA REGION - Professional

Special Instructions: Please verify the provider is approved for electronic claims submission through RelayHealth prior to submitting a remittance agreement. If you do not submit claims to RelayHealth and use a legacy NDC Health remittance product: RMIX, RMCX, or Postpro, please disregard this requirement.

Submitter ID 684401

Submitter Name Capario, Inc.

Customer ID 1004270

Billing ID 6844

Reference ID _____

Was 835 paperwork completed with the Claims Agreement?

Yes

No

40

Return completed agreements to:
RelayHealth
Attn: Enrollment Dept. (IADU-DC2)
301 Data Court
Dubuque, Iowa 52003



RelayHealth ERA Setup Form
(Please complete all sections for proper setup)

ERA Processing Days: (Choose either all days or specific day(s) of the week)

All days

Selected day(s) S M T W T F S

ERA Report Options: (Multiple choices)

Remittance Data Report (CPR401) (Available for all ERA file formats, contains RelayHealth's legacy remittance information with limited 835 data content)

Remittance Data Report in Check Number Order (CPR405) (Available for all ERA file formats, contains RelayHealth's legacy remittance information with limited 835 data content)

Provider Remittance Data (CPX401) (Available for ANSI 4010A1 HIPAA Enabled format only, contains listing of 835 ERA data elements)

Remittance Data Report (CPX425) (Available for all ERA file formats, contains 835 Remittance Notice data similar to Medicare's Standard Paper Remittance (SPR) report)

CLICK FOR REMITTANCE REPORT EXAMPLES

ERA Output Data File Format: (choose one)

Proprietary V.1 (Non-HIPAA)

Proprietary V.2 (Non-HIPAA)

ANSI 835 Version 3051 (Pre-HIPAA)

ANSI 835 Version 4010 (Pre-HIPAA)

ANSI 835 Version 4010A1 (HIPAA-Enabled)

ERA Batching Options for ANSI 835 4010A1 HIPAA-Enabled Format: (choose one)

Option 1 - One file per payor (May contain multiple checks)

Option 2 - Multiple files per payor (Each file may contain multiple checks, combined into one mailbox file)

Option 3 - One file per check (Combined into one mailbox file)

Option 4 - One file per check (One mailbox file per check)

Option 5 - Not Available

Option 6 - Not Available

Option 7 - Use check date alone(One mailbox file per check date)

ERA File Format Options for ANSI 835 4010A1 HIPAA-Enabled Format: (choose one)

Wrapped File (Continuous stream of data)

Unwrapped File (CR/LF after each segment)

ERA Processing Options: (choose one)

Express (Remittance is processed and sent as soon as it is received)

Collect (Remittance is processed and sent once per day)

This page is not required by the payor; however the below information is required by RelayHealth for this payor.

Provider Name

Provider ID

Tax ID

NPI



**SCHEDULE CR
TO
CONSENT TO RECEIVE ELECTRONIC REMITS**

AGENT ADDENDUM

This Addendum to the attached Agreement of Consent to Submit Claims Electronically (“Agreement”) acknowledges that Trading Partner has entered into an arrangement with _____, with its principal place of business at _____ (“Agent”) to provide third party services to Trading Partner.

1. **APPOINTMENT.**

Trading Partner has appointed an Agent to provide certain services to Trading Partner that necessitate Agent being able to take advantage of the electronic services as described in the attached Agreement is being made available to Trading Partner in accordance.

2. **ACCESS.**

Health Plan shall provide the electronic services to Agent upon the same terms and conditions of the Agreement to be provided to Trading Partner.

3. **OBLIGATION OF AGENT.**

Agent shall have the same duties, rights and obligations as Trading Partner has agreed to under the terms of the Agreement.

4. **NOTICES.**

Any notices required or permitted to be given pursuant to this Addendum shall be in writing and addressed to the following mailing address or such other address as may be provided to the other in writing:

AGENT

**Excellus Health Plan, Inc.
EDI Solutions
165 Court St
Rochester, NY 14647**

5. **INCORPORATION.**

All terms and conditions of the Agreement are incorporated by reference into this Addendum. The Parties hereby agree to the provisions of the Addendum.

6. **SIGNATURES (REQUIRED):**

PHYSICIAN (S):

Title: _____

Dated: _____

AGENT’S NAME:

Title: _____

Dated: _____



Mail to:

Excellus Health Plan, Inc.
EDI Solutions
165 Court St
Rochester, NY 14647

Practice Information

Practice Name: _____

Practice Address: _____

City: _____

State: _____ Zip: _____

Practice Contact

Name: _____

Phone: _____ Fax: _____

Email: _____

Practice NPI: _____

Practice Tax Id Number: _____

Billing Service: Yes () No ()

**If yes, please be sure to complete the following. If no, please skip to 'Software Vendor'*

Billing Service/Clearinghouse Information

Billing Service:

Name: _____

Phone: _____ Fax: _____

Email: _____

Clearinghouse:

Name: _____

Phone: _____ Fax: _____

Email: _____

Submitter ID: _____

Effective Date: _____

Signature: _____

****Signature required by physician or authorized person to sign on behalf of practice**



Software Vendor

Name: _____

Phone: _____

Submitter ID: _____

Effective Date: _____

Signature: _____

**Signature required by physician or authorized person to sign on behalf of practice