



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 Capital Blue Cross/KHP Central (54720)

To enroll with Capital Blue Cross/KHP Central for ERAs complete and send the payer agreement directly to the payer. 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 person or Account Manager. ERAs 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 EFTs in order to receive their ERAs
- Charge an additional fee for EFTs/ERAs
- Require you to enroll for EFTs on this ERA enrollment form.

Guidelines for Enrolling with this Payer

1. Mail the completed Blue Cross/Capital Advantage Insurance Co EDI Agent Designation Form to:

Capital Blue Cross
Attn: Georganna Lerch, Mail Drop 3631
2500 Elmerton Avenue
Harrisburg, PA 17110-9764

2. Fax or mail the 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
For Portal Users: Enroll using the Capario Portal Enrollment Tool.
The ERA Enrollment Request Form is not needed.

**Capital BlueCross/Capital Advantage Insurance Company
Electronic Data Interchange (EDI) Agent Designation Form**

This is to advise Capital Blue Cross and its wholly owned affiliates that _____ (Provider Name) has

appointed _____ (Agent Name) as our agent
for the following purposes:

(Please check all that apply for Capital BlueCross purposes):

- Submission of Professional claims via HIPAA Compliant ANSI 837
- Submission of HIPAA compliant ANSI 270/271 (Eligibility) transactions
- Submission of HIPAA compliant ANSI 276/277 (Claim Status) transactions
- Receive Electronic Remittance Advice via HIPAA Compliant ANSI 835
- Submission of HIPAA compliant ANSI 278 (Health Services Review) transactions
- Other (Describe below)

Description of Agency Purposes:

List Provider Numbers Covered by this Agency Agreement:

List National Provider Identifier (NPI) Numbers Covered by this Agency Agreement:

{Please provide Type 2 – Organization NPI(s), not Type 1 – Individual NPI(s)}

Capital BlueCross is authorized to treat the Agent as though it was the Provider for the purposes noted above.

The Provider understands that Capital BlueCross will be relying on this representation for claims processing purposes and for purposes of releasing confidential information. Provider confirms that the Agent has signed a written agreement pursuant to which it has agreed to treat any information that it receives from Capital BlueCross as confidential, and in accordance with all applicable laws and regulations.

Further, in consideration of Capital BlueCross' acceptance of the Agent, the Provider agrees that it will indemnify and hold Capital BlueCross harmless for any and all damages, claims and expenses that Capital BlueCross may incur or that may be asserted against Capital BlueCross as a result of the negligent or intentional actions of the Agent in carrying out its duties in connection with the purposes noted above.

Capital BlueCross shall be entitled to rely on this letter until revoked in writing.

Provider understands that Capital BlueCross reserves the right to modify its policies relating to the release of confidential information, including the release of subscriber information to providers or their agents, at any time.

Signature: _____ **Phone #:** _____
(Must be an Officer of the Provider)

Print Name: _____ **Email:** _____

Title: _____ **Date:** _____