Electronic Data Interchange (EDI) 837 Claims Enrollment Form and 835 Electronic Remittance Advice (ERA)

Thank you for your interest in electronically transmitting information to Alameda Alliance for Health (Alliance). This Alliance Electronic Data Interchange (EDI) Claims Enrollment Form and 835 Electronic Remittance Advice (ERA) allows providers to enroll in our EDI exchange to submit claims electronically and receive ERA data.

Instructions

1. Please complete the form and Trading Partner Agreement.
    a. Print clearly or type all the fields.
2. Submit the documents via mail, fax, or email to:

    ATTN: IT Department – EDI Enrollment
    Alameda Alliance for Health
    1240 South Loop Road
    Alameda, CA 94502
    Fax: **1.510.747.4290**
    Email: **edisupport@alamedaalliance.org**

For any questions, please call the Alliance EDI Department at **1.510.373.5757**.

Please Note: Providers who are not contracted with the Alliance are required to send us a copy of their W-9 form before we can complete enrollment.

Please submit a current W-9 form as a separate attachment via mail, fax, or email to:

ATTN: Data Systems
Alameda Alliance for Health
PO Box 2818
Alameda, CA 94501

Fax: **1.510.373.5970**
Email: **edisupport@alamedaalliance.org**

Section 1: EDI Enrollment Information

Today's Date (MM/DD/YYYY): ______________________

Desired Production Date (MM/DD/YYYY): ______________________

Section 2: Submitter Information

(Please Note: The exact name below should appear on inbound EDI claims)

Company/Provider Name: ______________________

Tax Identification Number (TIN) **or** Unique Physician Identification Number (UPIN) (if applicable): ______________________

Group National Provider Identifier (NPI) (if applicable): ______________________

Individual NPI (if you have multiple NPIs, please fill out "Providers with More Than One (1) NPI" on page six (6) of this form): ______________________

NPI Effective Date (MM/DD/YYYY): ______________________

Address: ______________________

City: ______________ State: __________ Zip Code: __________

Phone Number: ______________ Fax Number: ______________

Section 3: Contact Information

Name: ______________________

Phone Number: ______________ Fax Number: ______________

Email Address: ______________________

Remittance Advice Contact (if different from above):

Name: ______________________

Phone Number: ______________ Fax Number: ______________

Email Address: ______________________

Section 4: Transmission/Format Information

Submitter plans to transmit/receive the following transactions (select all that apply):

- ☐ Professional Health Claims (ASC X12N 837-005010X222A1)
- ☐ Institutional Health Claims (ASC X12N 837-005010X0223A2)
- ☐ Health Care Remittance Advice (ASC X12N 835-005010X0221A1)

Please Note: Please submit a current W-9 form as a separate attachment. 837 Claims are mandatory; 835 Remittances are optional.

Section 5: Clearinghouse Information
The Alliance will receive files directly from a submitter or via the submitter's clearinghouse. All clearinghouse fees are the submitter's responsibility. It is also the submitter's responsibility to secure a Business Associate Agreement (BAA) with its clearinghouse. If you indicate below that a BAA is not in place, the Alliance will not send any protected health information (PHI) to the clearinghouse on the submitter's behalf. The submitter must provide the Alliance with a written notice 30 days prior to terminating an active BAA with its clearinghouse. Do you currently use a clearinghouse for electronic transmissions? ☐ No ☐ Yes If **yes**, what is the provider's Clearinghouse Name? ______________________________

Trading Partner Agreement

(This should be signed by the provider)

This agreement is made between Alameda Alliance for Health ("Plan") and _______________

("Trading Partner") as of _______________ day of ____________________, 20______. This agreement provides the terms and conditions governing electronic transfers of data between Plan and Trading Partner (collectively "Parties"). Both Parties acknowledge and agree that the privacy and security of data held by or exchanged between them is of utmost priority. Both Plan and Trading Partner agree to take steps reasonably necessary to ensure that electronic transactions between them conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan's Electronic Data Interchange (EDI) Enrollment Form, and the then-current version of the Plan companion guides. This agreement will remain in effect until terminated according to the terms listed in this agreement. This agreement cannot be altered or amended without a written statement signed by both Parties.

I. Term and Termination

This agreement will remain effective indefinitely, beginning on the effective date of this agreement. Either Party may voluntarily terminate this agreement by providing written notice to the other Party thirty (30) days in advance of the termination date. If a Party breaches any material obligation of this agreement, the other Party may terminate this agreement immediately upon providing written notice to the other Party.

II. Obligations of the Parties

1. Each Party will be responsible for and take reasonable care to ensure that the information submitted in each electronic transaction by itself, its employees, or its agents is accurate, complete, and truthful.
2. Each Party will take reasonable precautions to limit the disclosure of the electronic data to authorized personnel on a need-to-know basis. The Plan and Trading Partner will notify the other Party of a termination of its relationship with a previously authorized employee or vendor (i.e., clearinghouse), that may require action to foreclose submission and receipt of transactions by person or vendor no longer authorized to act on its behalf.
3. Parties will not disclose the electronic data to any other person or organization without the express written permission of the subject of the data (i.e., the Plan's member or the Trading Partner's patient/customer) unless such disclosure is permissible by State or Federal law. Plan and Trading Partner will notify the other Party if it becomes aware of any use or disclosure that is not expressly permitted by this agreement.
4. Each Party will treat the information sent and received electronically as proprietary and will not use the information for any purpose or in a manner that would violate any privacy, security, or confidentiality laws or regulations, including, but not limited to, the HIPAA law.
5. Each Party will put appropriate safeguards in place to protect patient-specific data from improper access and will maintain the confidentiality of any security access codes.
6. Both Parties must agree that adequate testing has been completed before "live" production submissions will be transmitted or accepted to or from the other Party.
7. Plan and Trading Partner will not consider the other Party's electronic submission "received" (and will not "date stamp" the transaction) until the file has passed the Plan's initial edits.
8. Each Party will pay its own costs, charges, or fees it may incur as a result of transmitting electronic transactions to, or receiving electronic transactions from, the other Party.
9. Each Party will retain all original source documentation that supports the electronic data submission for at least six years and as required by applicable state and federal laws. Plan and Trading Partner shall have access to the other Party's original source documentation for auditing and verification purposes. Both Parties will research and correct any data discrepancies at their own expense. If a discrepancy is identified in either Party's original source documentation, both Parties agree to implement corrective action that will ensure an accurate and prompt resolution, which may include adjusting any incorrect payments identified as a result of such audit. Anyone who misrepresents or falsifies information relating to a claim may, upon conviction, be subject to fines and/or imprisonment under Federal law.
10. The Plan and Trading Partner will notify the other Party promptly if any transmitted data is received in an unintelligible or garbled form. Both Parties agree to retransmit the original transmission if a data transmission is lost or indecipherable.
11. Plan agrees to provide an acknowledgement of receipt of the Trading Partner's electronic data submission.

III. Indemnification

The Plan and Trading Partner shall hold harmless and indemnify the other Party from any and all claims, liabilities, judgments, damages, or judgments asserted against, imposed upon, or incurred due to its own negligence, intentional wrongdoing, or violation of this agreement.

IV. Authorized Signature

I am authorized to sign this agreement on behalf of said Trading Partner. I have read and agree to the foregoing provisions and acknowledge the same by signing below.

Alameda Alliance for Health Trading Partner

Signature: ____

Printed Name: ____

Printed Title: ____

Date: ____________________

ALAMEDA Alliance FOR HEALTH

Providers With More Than One (1) National Provider Identifier (NPI)

If there is more than one (1) NPI associated, please complete this list and attach it to the Alliance Electronic Funds Transfer (EFT) Authorization Form. Provider Groups that receive payments under the group number only need to complete a single enrollment form for the Group NPI. However, members of Provider Groups who also bill individually may enroll by submitting a separate enrollment form using their individual provider number.

Provider Group/Individual Name	Provider Group/Individual NPI	For Alliance Use Only