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**Submit the completed Payer Request Form to:**  
Inovalon Enrollment  
[enrollmentsupport@inovalon.com](mailto: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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**Questions or need assistance?**

Contact Inovalon Enrollment Department at 888.499.5465 or [enrollmentsupport@inovalon.com](mailto:enrollmentsupport@inovalon.com)

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**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:

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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## INSTRUCTIONS

### Payer Specific Enrollment Instructions

1. Complete the Providers Information Section and the Providers Information Section.
2. **If you are a Hospital or Facility, please include your Medicare UPIN number in the Other Identifiers – Assigning Authority field. This is a required field.**
3. Complete the Providers Contact Information Section.
4. Complete the Electronic Remittance Advice Information. The Method of Retrieval is prefilled.
5. Do not alter the prefilled information in the Electronic Remittance Advice Clearinghouse fields.
6. Leave the Electronic Remittance Advice Vendor Information blank.
7. Choose the Reason for submission
8. Sign and date the form.
9. Return Payer Forms and INOVALON request form to: [enrollmentsupport@inovalon.com](mailto:enrollmentsupport@inovalon.com).

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Horizon Blue Cross Blue Shield of New Jersey

## HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY 835 ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT FORM

The Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) Electronic Remittance Advice (ERA) Enrollment Form is **ONLY** for distribution by authorized Horizon BCBSNJ Trading Partners. Providers interested in participating in the Horizon BCBSNJ ERA Program must complete the ERA Enrollment Form and submit to an authorized Horizon BCBSNJ Trading Partner. Please e-Mail [HorizonEDI@HorizonBlue.com](mailto:HorizonEDI@HorizonBlue.com) for a current Authorized Horizon BCBSNJ ERA Trading Partners List. Missing information will delay your organization participation in the Horizon BCBSNJ ERA Program.

### *Provider Information Section*

Provider Name: \_\_\_\_\_

Provider Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ ZIP Code/Postal: \_\_\_\_\_

### *Provider Identifiers Information*

Provider Federal Tax ID (TIN) OR Employer ID Number (EIN): \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

Other Identifier(s) - Assigning Authority (MCARE UPIN Number, Suffix, etc.): \_\_\_\_\_

### *Provider Contact Information Section*

Provider Contact Name: \_\_\_\_\_

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

Email Address: \_\_\_\_\_

### *Electronic Remittance Advice Information*

Preference for Aggregation of Remittance Data (select one from below)

Provider Tax Identification Number (TIN): \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

Method of Retrieval: \_\_\_\_\_

The method in which the provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.)



Horizon Blue Cross Blue Shield of New Jersey

**Electronic Remittance Advice Clearinghouse Information**

Clearinghouse Name: ABILITY Network

Clearinghouse Contact Name: Enrollment Dept.

Clearinghouse Telephone Number: 888-340-5610

Clearinghouse Email Address: setup@ABILITYNetwork.com

**Electronic Remittance Advice Vendor Information**

Vendor Name: \_\_\_\_\_

Vendor Contact Name: \_\_\_\_\_

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

Vendor Email Address: \_\_\_\_\_

**Submission Information**

Reason for Submission (select one from below)

- New Enrollment
- Change Enrollment
- Cancel Enrollment

Authorized Signature (select from below):

Electronic Signature of Person Submitting Enrollment: \_\_\_\_\_

Written Signature of Person Submitting Enrollment: \_\_\_\_\_

Printed Name of Person Submitting Enrollment: \_\_\_\_\_

Printed Title of Person Submitting Enrollment: \_\_\_\_\_

Submission Date: \_\_\_\_\_

Submit completed form via Mail, e-Mail, or Fax to:

Horizon Blue Cross Blue Shield of New Jersey  
 EDI Services PP-11C  
 3 Penn Plaza East  
 Newark, NJ 07105-2200  
 Attention: Horizon-BCBSNJ ERA Enrollment

HorizonEDI@HorizonBlue.com

Fax Number: 1-973-274-4353



**Horizon BCBSNJ ERA Enrollment Form Glossary**

<b>Field Name</b>	<b>Description</b>
<b>PROVIDER INFORMATION SECTION</b>	
<b>Provider Name</b>	Complete legal name of institution, corporate entity, practice or individual provider
<b>Provider Address/Street</b>	The number and street name where a person or organization can be found
<b>City</b>	Associated with provider address field
<b>State/Province</b>	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country
<b>ZIP Code/Postal Code</b>	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities
<b>PROVIDER IDENTIFIERS INFORMATION SECTION</b>	
<b>Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)</b>	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity
<b>National Provider Identifier (NPI)</b>	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions
<b>Other Identifiers</b>	<ul style="list-style-type: none"> <li>• Assigning Authority - Organization that issues and assigns the additional identifier requested on the form, e.g., Medicare, Medicaid</li> <li>• Trading Partner ID - The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor</li> </ul>
<b>PROVIDER CONTACT INFORMATION SECTION</b>	
<b>Provider Contact Name/Title</b>	Contact Name of a contact in provider office for handling ERA issues
<b>Telephone Number Telephone Number Extension</b>	Associated with contact person
<b>Email Address</b>	An electronic mail address at which the health plan might contact the provider



Horizon Blue Cross Blue Shield of New Jersey

<b>ELECTRONIC REMITTANCE ADVICE INFORMATION SECTION</b>	
<b>Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)</b>	Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFT payment <ul style="list-style-type: none"> <li>• Provider Tax Identification Number (TIN)</li> <li>• National Provider Identifier (NPI)</li> </ul>
<b>Method of Retrieval</b>	The method in which the provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.)
<b>CLEARINGHOUSE INFORMATION SECTION</b>	
<b>Clearinghouse Name</b>	Official name of the provider’s clearinghouse
<b>Clearinghouse Contact Name</b>	Name of a contact in clearinghouse office for handling ERA issues
<b>Telephone Number</b>	Telephone number of contact
<b>Email</b>	Address An electronic mail address at which the health plan might contact the provider’s clearinghouse
<b>VENDOR INFORMATION SECTION</b>	
<b>Vendor Name</b>	Official name of the provider’s vendor
<b>Vendor Contact Name</b>	Name of a contact in vendor office for handling ERA issues
<b>Telephone Number</b>	Telephone number of contact
<b>Email Address</b>	An electronic mail address at which the health plan might contact the provider’s vendor
<b>SUBMISSION INFORMATION SECTION</b>	
<b>Reason for Submission</b>	New Enrollment Change Enrollment Cancel Enrollment
<b>Authorized Signature</b>	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment Electronic Signature of Person Submitting Enrollment Written Signature of Person Submitting Enrollment A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity Printed Name of Person Submitting Enrollment The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment Printed Title of The printed title of the Person Submitting Enrollment person signing the form; may be used with electronic and paper-based manual
<b>Submission Date</b>	The date on which the enrollment is submitted CCYYMMDD23