

## SECTION 3 - ENROLLMENT AND TESTING PROCEDURES

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## **EDI PROVIDER ENROLLMENT PROCESS**

When a provider wishes to enroll in electronic billing, the EDI Provider Enrollment packet must be completed and submitted for processing. It includes an EDI Provider Information form and the necessary agreements.

An EDI Provider Enrollment packet is enclosed beginning on the next page. You can duplicate this packet as often as needed. System Vendors, Billing Services and Clearinghouses should complete Section 2 or Section 3 of the EDI Provider Information Form prior to duplication and distribution to your clients to insure these sections are accurate.

NOTE: A new provider to you, who previously had been set up on our EDI data base to bill electronically, and whom we have all the necessary agreements on file, will only need to submit a new enrollment form, not new agreements.

- If the provider is changing systems **vendors**, they will only need to provide us with the EDI Provider Information Form. We will accept this completed form by fax. If the vendor has been approved for production, the provider will not need to test.
- If the provider is changing their **billing service or clearinghouse** to one who is approved to submit production claims will not need to submit an enrollment packet. The new billing service / clearinghouse may begin submitting the providers claims immediately without any paperwork being received by us.

To avoid duplication of paperwork, you may contact the EDI Helpline to verify if your new provider is already setup and has the necessary agreements on file.

BLUE CROSS AND BLUE SHIELD OF TEXAS, INC.\*

dba TrailBlazer Health Enterprises

Texas Health Information Network (THIN)

EDI PROVIDER INFORMATION FORM

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

SECTION 1 (to be completed by Provider)

Provider Data		
NAME:		
ADDRESS:		
CITY:	ST:	ZIP:
PRIMARY CONTACT:		
PHONE NUMBER:	FAX NUMBER:	
MEDICARE PROVIDER NUMBER:		
**BLUE CROSS AND BLUE SHIELD OF TEXAS PROVIDER NUMBER:		
**COMMERCIAL PROVIDER # (tax ID):		
**MEDICAID PROVIDER #:		
Check the following which are applicable: <input type="checkbox"/> Provider is Submitter (Provider submits claims directly from their office.) <input type="checkbox"/> Provider is With Billing Service/Clearinghouse <input type="checkbox"/> Provider is With Other Providers (List Provider ID #'s: _____) <input type="checkbox"/> Please send me the free On-Line Inquiry Software		

\*\*Applicable to Texas Providers Only

SECTION 2 (to be completed by Vendor)

EDI Software Vendor Data		
COMPANY NAME:		
PRIMARY CONTACT:	PHONE:	FAX:
BCBSTX VENDOR CODE :		
Indicate the format and version you will be submitting: NSF ___ UB92 ___ ANSI ___ Version ___		

SECTION 3 (to be completed by Billing Service/Clearinghouse)

EDI Billing Service / Clearinghouse Data		
COMPANY NAME:		
PRIMARY CONTACT:	PHONE:	FAX:
BCBSTX SUBMITTER ID:	PASSWORD:	
Indicate the format and version you will be submitting: NSF ___ UB92 ___ ANSI ___ Version ___		

\*An Independent Licensee of the Blue Cross and Blue Shield Association

## EDI PROVIDER ENROLLMENT PACKET INSTRUCTIONS

The attached documents *must* be completed and *must* be returned to us by mail for processing. (*No Faxes*)

### Electronic Data Interchange (EDI) Provider Information Form

#### SECTION 1-- Provider Data

To be completed by the Physician, Supplier or Group Practice. Provide the Physician, Supplier or Group Name with the complete street address, city, state, zip code, primary contact's name, phone number, fax number, and provider numbers. **NOTE:** If you are requesting approval for multiple physician, supplier or group identification numbers a separate EDI Provider Enrollment Packet *must* be completed for each individual billing number. If you are enrolling a group practice, only one Enrollment Packet should be completed with the group billing identification number.

Provider is Submitter: Place a check in this field if you will be submitting electronically direct to us from your office using the software indicated in Section 2. This *must* be checked if applicable.

Provider is with Billing Service or Clearinghouse: Place a check in this field if your claims will be submitted electronically to us by a billing service or clearinghouse company indicated in Section 3. This *must* be checked if applicable.

Provider is with other Providers: Place a check in this field and provide the provider numbers if there is more than one physician, supplier or group billing electronically from your office. In this instance, you will be assigned a special submitter number to be used for all providers. **NOTE:** Only individual practice or group numbers are needed. Physician's individual numbers that are within a group billing practice are not needed.

On-Line Inquiry: Please check if you are interested in receiving the free On-Line Inquiry Software.

#### SECTION 2--EDI Software Vendor Data

If you received this packet from your software vendor, this section may have already been completed for you. If it was not, you *must* provide the company name of your software vendor.

#### SECTION 3--EDI Billing Service or Clearinghouse Data

If you received this packet from your billing service or clearinghouse this section may have already been completed for you. If it was not, you *must* provide the company name of your billing service or clearinghouse that will be submitting your claims.

### Electronic Data Interchange (EDI) Agreement

This agreement *must* be signed by the physician, administrator or equivalent legal representative for Texas providers.

### Medicare Electronic Data Interchange (EDI) Enrollment Form

This agreement *must* be signed by the physician, administrator or equivalent legal representative if you will be submitting Medicare claims.

Before returning these required documents, make copies for your records and make sure you have completed the following steps:

1. Complete the EDI Provider Information Form;
2. Complete and sign the Electronic Data Interchange (EDI) Agreement (Texas providers only);
3. Complete and sign the Medicare Electronic Data Interchange (EDI) Enrollment Form (Medicare only);
4. Return all original documents together to the following address:  

<b>Mailing Address:</b>	<b>Delivery Address:</b>
Provider Automation 2-R-S	Provider Automation 2-R-S
Blue Cross and Blue Shield of Texas	Blue Cross and Blue Shield of Texas
PO Box 655924	901 South Central Expressway
Dallas, TX 75265-5924	Richardson, TX 75080

Once the completed provider enrollment packet has been received, the documents will be processed. A confirmation will be faxed to the submitter as notification to begin filing claims electronically. This process should take approximately 2 days from the date of receipt. Remember, your mail time is approximately 3 to 5 days.

It is very important that you complete and return the entire enrollment packet as described above. **Incomplete packets will not be processed and will be returned to the submitter.**

If the submitter has not received a confirmation nor a returned packet in 2 weeks, feel free to contact our office. Otherwise, please avoid contacting our office for enrollment status as this could delay the process. Our sincere effort is to avoid any unnecessary delays and to expedite your request as soon as possible.

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**MEDICARE ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM**

The provider agrees to the following provisions for submitting Medicare claims electronically to HCFA or to HCFA's contractors.

A. The Provider Agrees:

1. That it will be responsible for all Medicare claims submitted to HCFA by itself, its employees, or its agents.
2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except HCFA and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.
3. That it will submit claims only on behalf of those Medicare beneficiaries who have given their written authorization to do so, and to certify that required beneficiary signatures, or legally authorized signatures on behalf of beneficiaries, are on file.
4. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:
  - o Beneficiary's name,
  - o Beneficiary's health insurance claim number,
  - o Date(s) of service,
  - o Diagnosis/nature of illness, and
  - o Procedure/service performed.
5. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the provider and shall have access to all original source documents and medical records related to the provider's submissions, including the beneficiary's authorization and signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to the applicable provisions of the Social Security Act, Federal regulations, and HCFA guidelines.
6. That it will ensure that all claims for Medicare primary payment have been developed for other insurance involvement and that Medicare is the primary payer.
7. That it will submit claims that are accurate, complete, and truthful.
8. That it will retain all original source documentation and medical records pertaining to any such particular Medicare claim for a period of at least 6 years, 3 months after the bill is paid.
9. That it will affix the HCFA-assigned unique identifier number of the provider on

each claim electronically transmitted to the contractor.

10. That the HCFA-assigned unique identifier number constitutes the provider's legal electronic signature and constitutes an assurance by the provider that services were performed as billed.

11. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.

12. That it will acknowledge that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this Agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law.

13. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from HCFA or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with ¶1106(a) of the Act).

14. That it will research and correct claim discrepancies.

15. That it will notify the contractor or HCFA within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. The Health Care Financing Administration will:

1. Transmit to the provider an acknowledgement of claim receipt.

2. Affix the intermediary/carrier number, as its electronic signature, on each remittance advice sent to the provider.

3. Ensure that payments to providers are timely in accordance with HCFA's policies.

4. Ensure that no contractor may require the provider to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest. The contractor will make alternative means available to any electronic biller to obtain such services.

5. Ensure that all Medicare electronic billers have equal access to any services that HCFA requires Medicare contractors to make available to providers or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:

Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by the HCFA under this document.

This document shall become effective when signed by the provider. The responsibilities and obligations contained in this document will remain in effect as long as Medicare claims are submitted to HCFA or the contractor. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. Signature

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

\_\_\_\_\_  
Provider's Name

\_\_\_\_\_  
Original - Authorized Signature (Stamped or duplicated signatures will not be accepted)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Date

## ELECTRONIC DATA INTERCHANGE (EDI) AGREEMENT

This Agreement between

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Name, Address (*please print or type*)

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Provider Number

(herein called "Provider") and Blue Cross and Blue Shield of Texas, Inc., dba TrailBlazer Health Enterprises, Inc. outside the State of Texas (herein called "Contractor") is made as of , 19\_\_, and shall remain in effect until terminated.

Provider is the hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice, physician, or supplier signing this agreement. If Addendum A is attached and signed, this agreement shall be applicable to Clearinghouse claims.

The Provider desires to facilitate, through the use of electronic formats, claims submission and payment by electronically transmitting and receiving data that are in specific machine readable formats. Contractor and the provider intend such transactions to be legally valid and enforceable and has the same force and effect under the law as a paper claim form.

A. The Provider Agrees:

1. Machine readable claims whether assigned or nonassigned submitted to Contractors by Provider or by any billing agent he might choose to employ shall contain true, accurate, and complete information.
2. Provider will review for accurate claims payment information from claims processed by Contractors. The Provider may "appeal" a payment decision to the Contractors within the requisite number of days for the appropriate program under which claim was filed.
3. The cashing of each check for claims paid to the Provider will be a representation and certification that the Provider presented the bill for the services indicated on the machine readable claim and that the services indicated on the machine readable claim were personally rendered by the Provider or under his personal supervision.
4. The submission of such machine readable claims whether assigned or nonassigned is a claim for payment and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim or information that is required pursuant to this Agreement may, upon conviction, be subject to fine and/or imprisonment under applicable federal and/or state law.

5. Every machine readable claim entry submitted by Provider, or any person or billing agent submitted on appropriate paper forms.
6. All source documents pertaining to each machine readable claim submitted by Provider will be retained by Provider or his billing agent for a period of six (6) years after the month in which the claim was submitted to Contractor.
7. Provider is solely responsible for the accuracy of all machine readable claims submitted to Contractor by Provider, or any person or billing agent he may choose to employ.
8. To research and correct all billing discrepancies, and any incorrect payments discovered will be adjusted according to the applicable provisions then in effect for such claims.
9. To permit the Contractor to conduct on-site audits, reviews, and inspections to confirm machine readable claims information submitted by Provider and to have access to all source documents and medical records, financial records, and any other records related to any machine readable claim.

B. In support of Section A above, the Provider agrees to the following administrative requirements:

The Provider shall assume all necessary personal responsibility and review of the internal procedures used to develop, transcribe, data enter, and transmit all required claim information for payment. The Provider shall also assume responsibility for verification of charges submitted for payment. This administrative control and review shall consist of the following minimum requirements.

1. Not to disclose any information concerning a patient to any other person or organization, except Contractor, without the express written permission of the patient or his/her parent or legal guardian or as required by State or Federal law.
2. To ensure that patient eligibility data are used only for the purpose of preparing and filing accurate claims and should not be construed as any kind of guarantee of payment to the provider.
3. To submit claims only on behalf of those patients who have given their written authorization to do so, and to certify that required patient signatures, or legally authorized signatures on behalf of patients, are on file.
4. To ensure that every electronic entry can be readily associated and identified with information:
  - Patient's name,
  - Patient's health insurance claim number,
  - Date(s) of service,
  - Diagnosis/nature of illness,
  - Procedure/service performed, and
  - Provider's signature.
5. To provide and maintain the equipment, software, services and testing necessary to effectively and reliably transmit claims, and to use other available data inquiry services, such as receipt of electronic remittance advice or claim status. If Addendum

B is attached and initialed, this agreement shall be applicable to charges for equipment leased from the Contractor.

6. To prevent unauthorized users from submitting claims or committing other data security violations. If Addendum C is attached and initialed, this agreement shall be applicable to providers who have executed an agreement to submit electronic claims on behalf of other health care providers on equipment leased from the Contractor.

C. The Contractor and Provider agree:

1. That Contractor will accept from Provider, or any person or billing agent he may choose to employ, machine readable claims according to the requirements of this agreement and process such claims in the same manner as it (they) would process claims submitted by Provider on appropriate paper claim forms, but only upon and subject to the terms and conditions of this Agreement.
2. That all machine readable claims submitted by Provider, or any person or billing agent he may choose to employ will (1) be in a format acceptable to Contractor for the program involved; (2) be submitted in accordance with Contractor's machine readable claims billing procedures; (3) contain all information required by Contractor; and (4) utilize the appropriate procedure and diagnosis codes in use in Contractor's claims processing systems.
3. The Contractor shall not be held responsible for any changes in the patient's eligibility or claims status that may adversely affect the provider.
4. This Agreement shall become effective as of the date first hereinabove written, when executed by all parties and shall remain in effect until terminated by Provider or Contractor. Provider or Contractor may terminate this Agreement or any addendum to this agreement by giving thirty (30) days prior written notice thereof of intent to terminate.

IN WITNESS WHEREOF, Contractor and Provider have caused this Agreement to be executed by their duly authorized representatives.

Contractor:  
Blue Cross & Blue Shield of Texas, Inc.

Provider:

\_\_\_\_\_  
Bruce Francis, Vice President  
Information Technology Group

\_\_\_\_\_  
Authorized Signature

By:\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Title:\_\_\_\_\_

**ADDENDUM A**  
**BLUE CROSS AND BLUE SHIELD OF TEXAS, INC**  
**TEXAS HEALTH INFORMATION NETWORK (THIN)**  
**CLEARINGHOUSE AGREEMENT**

This Addendum shall only be applicable when the Provider desires to facilitate an Electronic Data Interchange Agreement for the purposes of submitting electronic claims to and receiving additional EDI transactions, when available, from Other Payors through the Texas Health Information Network Clearinghouse.

Whereas, Provider and Contractor have previously entered into an Electronic Data Interchange Agreement;

Whereas, Provider now desires to have Contractor provide an Other Payor Clearinghouse;

Therefore, for good and valuable consideration, Contractor and Provider agree as follows:

1. Expenses: All expenses and costs incurred by either party, in connection with the performance of its duties under this Agreement, and which are the responsibility of such party incurring such expenses, shall be borne by the party incurring such expense, except as otherwise specifically provided herein, or as agreed to in writing by the parties in advance of incurring such expense. Therefore, Contractor will not charge Provider for the electronic submission of Other Payor claims. Additional EDI transactions, as they become available, may incur expenses warranting fees which will be agreed to in writing by all parties.
2. Term: The term of this agreement shall be effective from the date of Addendum A and shall continue until the earlier of (a) the termination of the Addendum or (b) the cancellation of any or all services by either party without cause upon thirty (30) days prior written notice to the other party.
3. Blue Cross and Blue Shield of Texas, Inc. Obligations:
  - a. To electronically receive claims data submitted by providers, and forward claims data to Payor.
  - b. Additional Electronic Data Interchange (EDI) transactions will be supported when mutually agreed to in writing by the parties. Fees relative to these transactions will be included in an addendum to this agreement.
  - c. To process inquiries from providers directly relating to the transmission of electronic insurance claims only. Contractor will not be held responsible in any way for limitations, if any, in the provider's hardware or software, or for inquiries concerning Other Payor claims adjudication or other services.
4. Provider's Obligations: In using the Texas Health Information Network Clearinghouse for Other Data, Provider shall adhere to the requirements of Section A of the Agreement, comply with all payor requirements relating to the transmittal and receipt of Other Data, and agrees to defend, indemnify, and hold harmless Contractor against any and all loss, liability, damage, penalty and expense, including attorneys' fees, or other cost or obligation which results from, or arises out of, any administrative proceeding, liability, damage, claim, lawsuit, demand, settlement, or judgment brought against or incurred by Contractor resulting from or arising out of (a) any breach, intentional or otherwise, by Provider of a provision of the Agreement, including this Addendum B, or (b) the performance by Contractor of its obligations under this Agreement, unless such administrative proceeding, liability, damage, claim, lawsuit, demand, settlement, or judgment directly results from the gross negligence, bad faith, or willful misconduct of Contractor.
5. Confidentiality: Notwithstanding the foregoing, Contractor may use abstract statistical data in the formulation of statistical summaries or samplings, provided, however, any such summary or sampling shall

not disclose the identity of the Payor, claimants, or patients included in such summary or sampling.

- 6. Limitation on Liability: Contractor shall not be liable for any liability, damage (direct, indirect, or special), loss or delay caused or alleged to be caused directly, incidentally or consequentially by clearinghouses which facilitate Provider's submission of claims to Other Payers. No action arising out of any claimed breach of the Agreement by Contractor may be brought more than one (1) year after the cause of action has arisen.

IN WITNESS WHEREOF, each of the parties has caused this Addendum A to be executed on its behalf by its duly authorized officers, as of the day and year written below.

SUBSCRIBED to by the parties hereto:

Blue Cross and Blue Shield of Texas, Inc.

Authorized Signature: \_\_\_\_\_

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

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

Authorized Signature: \_\_\_\_\_

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

Form No. EDIA-Addendum A

**ADDENDUM B  
COMPUTER TERMINAL LEASE**

This Addendum B shall only be applicable when Contractor installs or arranges for the installation of one or more computer terminals to be used for the purposes of this Agreement, at the location(s) specified by Provider.

The Provider hereby agrees to pay Contractor for: all transportation or freight costs for shipping equipment to the Provider; direct costs of installation; ongoing operational costs for telephone lines, modems, terminal(s); and paper and printer ribbons used in the printer. Contractor will invoice Provider for the lease costs of the equipment on a monthly basis at the below noted rate. Payment is due upon receipt of the invoice. The rate may be changed by the Contractor upon 60 days advance written notice to the Provider. Subsequent relocations of the equipment may result in additional expenses billed to the Provider, but such expenses will not exceed the actual costs incurred by Contractor.

Contractor hereby agrees to supply the Provider initial training in the use of the applicable machinery and a User Manual describing appropriate procedures for the Provider to follow in using the equipment.

This Addendum B shall remain in effect until terminated by either party upon 30 days written notice to the other. The equipment installed hereunder shall not be construed to become the property of Provider. Charges for repair of equipment damaged by Provider personnel shall be the responsibility of the Provider. Upon termination, all equipment installed under the terms hereof shall be promptly removed from Provider's specific location(s) by Contractor or Contractor's agent.

Monthly Rate \$ \_\_\_\_\_

Blue Cross and Blue Shield of Texas, Inc.

Authorized Signature: \_\_\_\_\_

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

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

Authorized Signature: \_\_\_\_\_

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

Form No. EDIA-Addendum B

**ADDENDUM C  
LEASED TERMINAL PROVIDER CLAIMS SUBMISSIONS  
FOR OTHER PROVIDERS**

Contractor and Provider desire an arrangement whereby Provider can submit bills electronically on behalf of other health care providers (herein called "HCP") in addition to their own claims submissions for provider reimbursement. HCP include hospitals, physicians and other health care suppliers.

1. Provider certifies that it will submit claims on behalf of those HCP who have given it written authorization to do so and that it will maintain these written authorizations during the term of this Agreement and will furnish true copies to Contractor upon request. Acceptance of such claims by Contractor from Provider is conditioned upon Contractor having an executed EDI Submission Agreement with each provider for whom claims are submitted.
2. Provider agrees to submit such claims to Contractor only in the specific format required by Blue Cross and Blue Shield of Texas, Inc.
3. Provider agrees that Contractor or the Secretary of Health and Human Services or his/her designees, have the right to audit and confirm for any purpose information submitted to Provider by such HCP.
4. Provider agrees that it is its obligation to research and correct any and all claim discrepancies caused by HCP.
5. Provider agrees to Contractor advance notice of any changes made in the status (including names and other appropriate identifiers) of HCP for whom Provider is authorized to bill. Contractor must approve the additional HCP for which Provider intends to submit claims.
6. Contractor may refuse for any reason to accept electronic medium claims submitted by Provider from any HCP.
7. Provider will ensure that every electronic entry can be readily associated and identified with a source document from a HCP.
8. All other provisions of this Agreement concerning confidentiality of information, access to records, etc., continue to apply to this additional agreement between the parties.

Blue Cross and Blue Shield of Texas, Inc.

Authorized  
Signature: \_\_\_\_\_

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

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

Authorized  
Signature: \_\_\_\_\_

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



## TESTING REQUIREMENTS

- **Existing System Vendors and Submitters**

EDI Systems vendors and submitters, who currently have a provider customer base who submit electronic claims to the Texas Health Information Network for one of the following lines of business, can enroll new providers for the same lines of business without further testing.

- Blue Shield
- Commercial
- Dental
- HMO Blue Medicaid
- Medicare B

(Note: You will need to contact NHIC for Texas Medicaid testing requirements.)

Although we do not require approved systems vendors and submitters to test new providers, we encourage all vendors and submitters to test new versions, formats and/or enhancements to their software programs to ensure their electronic claims software continues to meet format and quality standards. Vendors can use their 6-digit vendor code as the submitter ID to transmit a file for test purposes. You will need to contact the EDI Helpline for a password.

- **New EDI System Vendors and Submitters**

New EDI System vendors and submitters including an individual provider who has programmed their own system will be required to complete a testing phase before production status can be granted to ensure accurate format and claims data quality. Once the vendor or submitter is granted approval status, they can enroll new providers without additional testing.

The submitter of the test file must monitor the response file after each test submission to determine format and/or data elements to be corrected and re-tested. (Refer to Section 5) You will not receive any other form of notification for initial test results. Once a successful test file has been accepted with no errors, fax a completed EMC Production Request Form (Page 3.18) to Provider Automation. An EDI analyst will verify the test submissions for accuracy and fax back to the submitter a "Connect For Success" confirmation form (Page 3.19 or 3.20) within three (3) days. Do not attempt to submit production claims until you receive this form.

Test files should consist of a variety of at least 25 claims that represent the type of claims the vendor / submitter will be submitting once production status is achieved. Test claims will not be processed for payment but will be validated against production files so they must contain valid patient, procedure, diagnosis, and provider information. Since test claims will not be processed for payment, claims previously submitted for payment or claims which have not yet been submitted may be used.

For example, if a vendor or submitter has a provider whose specialty is ophthalmology and he performs eye exams and cataract surgery routinely. The test claims from this provider should include claims for eye exams and cataract surgery, office services and ambulatory surgical center services. If only eye exams are submitted on the test, production status may not be achieved.

In addition to the fields required for specific specialties, we request that test files include where applicable:

(General)

Multiple Place of Services (11, 12,21,22,32...)

Referring UPINs (x-ray, lab, consults, PT)

Medigap for Participating Providers

Secondary Ins (BCBS, Med. Assistance, Commercial)

MSP claims (paid amts., allowed amts., ins type code)

Narratives

Modifiers

Assistant Surgery (Mod 80 - with Facility ID)

Multiple Surgery's

Solo Practice

Group Practice (with Performing Provider Id #'s)

Purchased Test (with Indicator, Amount, Prov ID)

12 Detail lines

(Other)

Anesthesia/CRNA (with modifiers, minutes)

Independent Labs

Independent Radiology

Reference Labs

(Specialty's)

Ambulance (with GA0 record)

Podiatry

Chiropractic (with GC0 record)

Physical Therapy

EPO (with Initial EPO visits)

Testing validates the ability of a file to pass the THIN edits. Format testing checks:

- Layout of file
- Password to Submitter ID
- Version Numbers
- Record Sequencing
- Balancing
- Batch Types
- Batch Type to Files
- Batch ID
- Duplicate Batches
- Numeric Fields
- Date Fields
- Relationship Edits
- Field Values

Refer to Exhibit 5 for a listing of the NSF Error Messages.

Test results for telecommunicated submissions will be returned at the time of transmission. Refer to Section 5.

Test results for tape or cartridge submissions that are rejected are returned with the tape/cartridge by mail on the same day of the reject.

#### TEST DATA - BLUE SHIELD OF TEXAS SPECIFIC:

Blue Shield test claims must include examples of the following billing practices.

- In-Patient Hospital Services
- Out-Patient Hospital Services
- Claims for Insured
- Claims for Spouses/Dependents

#### TEST DATA - AMBULANCE CLAIMS

Ambulance test submissions must include claims for mileage, supplies, round trip transfers and special billings (e.g., waiting time) if these services are routinely rendered.

#### TEST DATA - CLEARINGHOUSE CLAIMS IN TEXAS

A clearinghouse commercial test file should include a variety of payors, especially Prudential and Travelers, if available.



**BLUE CROSS AND BLUE SHIELD OF TEXAS, INC.\***  
**dba TrailBlazer Health Enterprises, Inc.**  
**Texas Health Information Network (THIN)**  
**CONNECT FOR SUCCESS**  
**Electronic Claims Filing Status**

**TO:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**CONFIRMATION**

**NAME:**

**SUBMITTER ID:**

**PASSWORD:**

**VENDOR ID:**

**EMC STATUS: PRODUCTION**

\_\_\_ **Medicare**

**EFFECTIVE DATE:**

**EMC TESTING REQUIRED:**

\_\_\_ **Medicare**

**COMMENTS:**

**SIGNATURE OF APPROVAL:**

**THANK YOU FOR CONNECTING WITH US**  
**EDI Helpline (972)766-5480**

**\*An Independent Licensee of Blue Cross and Blue Shield Association**

**BLUE CROSS AND BLUE SHIELD OF TEXAS, INC.\***  
**dba TrailBlazer Health Enterprises, Inc.**  
**Texas Health Information Network (THIN)**  
**CONNECT FOR SUCCESS**  
**Electronic Claims Filing Status**

**TO:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**\*\*Applicable To Texas Providers Only**

<b>CONFIRMATION</b>		
<b>EMC Provider ID (S):</b>		
<hr/>		
<b>PASSWORD:</b>	<b>SUBMITTER ID:</b>	
<hr/>		
<b>EMC Status: PRODUCTION</b>	<input type="checkbox"/> Medicare <input type="checkbox"/> Blue Shield ** <input type="checkbox"/> Commercial ** <input type="checkbox"/> Blue Cross **	<b>EFFECTIVE DATE:</b>
<hr/>		
<b>EMC Testing Required:</b>	<input type="checkbox"/> Medicare <input type="checkbox"/> Blue Shield ** <input type="checkbox"/> Commercial ** <input type="checkbox"/> Blue Cross **	
<hr/>		
<b>COMMENTS:</b>		
<hr/>		
<b>SIGNATURE OF APPROVAL:</b>		
<hr/>		

**THANK YOU FOR CONNECTING WITH US**  
**EDI Helpline (972)766-5480**

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