WELCOME TO OFFICE ALLY!

BLUECROSS BLUESHIELD IOWA AND SOUTH DAKOTA

HOW LONG DOES PRE-ENROLLMENT TAKE?
  o 1-2 business days

WHAT PROVIDER NUMBER DO I USE?
  o Provider Tax ID
  o NPI

WHERE SHOULD I SEND THE FORMS?
  o You should fax the forms to 800.691.1038
  o Be sure to include your email address on forms!

WHO CAN SIGN THE FORMS?
  o The provider if solo practice
  o The president, CEO or owner of the group if group or corporation

HOW DO I CHECK THE STATUS OF MY APPLICATION?
  o Call 800.407.0267 and give our submitter ID 000011475.
  o Ask if you have been linked to Office Ally submitter ID.
  o You may need to provide your Wellmark provider # or NPI number.
  o If you have been linked, you MUST call Office Ally to notify PRIOR to sending claims.
ELECTRONIC TRANSACTION REGISTRATION FORM

Electronic Commerce Solutions
636 Grand Avenue, Station 142
Des Moines, IA 50309
Toll Free 800-407-0267
Fax 800-691-1038

**A VALID PROVIDER ID FOR WELLMARK BLUE CROSS AND BLUE SHIELD OF IOWA OR SOUTH DAKOTA IS REQUIRED TO REGISTER**

<table>
<thead>
<tr>
<th>Submitter Name:</th>
<th>Office Ally, LLC.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact:</td>
<td>Eve DuBry</td>
</tr>
<tr>
<td>Phone:</td>
<td>(949) 464-9129</td>
</tr>
<tr>
<td>Fax:</td>
<td>(949) 376-6951</td>
</tr>
<tr>
<td>Submitter Address 1:</td>
<td>32356 S. Coast Hwy.</td>
</tr>
<tr>
<td>City:</td>
<td>Laguna Beach</td>
</tr>
<tr>
<td>State:</td>
<td>CA</td>
</tr>
<tr>
<td>Zip Code:</td>
<td>92651</td>
</tr>
<tr>
<td>County:</td>
<td>Orange</td>
</tr>
<tr>
<td>Email Address:</td>
<td><a href="mailto:info@officeally.com">info@officeally.com</a></td>
</tr>
</tbody>
</table>

Do you already have a submitter ID? (This is separate from your provider number) YES ☐ NO ☐
If yes, what is your Submitter ID? 000011475

As a result of HIPAA regulations, we need to know if you provide clearinghouse services for electronic transactions.

YES ☐ NO ☐

Please select a method for sending your electronic transactions: Internet Connection to INet (Web BBS) ☑ or Dial-Up to INet ☐

Will you be posting 835 transactions (Electronic Remittance Advice)? YES ☐ NO ☐ If "YES", please answer next question.
Do you have the capability to process 835 transactions (ERA)? YES ☐ NO ☐
If 835 transactions (ERAs) are to be received, deliver to the following submitter number: ____________________________

<table>
<thead>
<tr>
<th>Practice Management Software</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vendor Name:</td>
</tr>
<tr>
<td>Address 1:</td>
</tr>
<tr>
<td>Address 2:</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>State:</td>
</tr>
<tr>
<td>Zip Code:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name:</td>
</tr>
<tr>
<td>Address 1:</td>
</tr>
<tr>
<td>Address 2:</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>State:</td>
</tr>
<tr>
<td>Zip Code:</td>
</tr>
<tr>
<td>Phone: (     )</td>
</tr>
</tbody>
</table>

Lines of Business:
Blue Shield (Professional) ☐ Blue Cross (Institutional) ☐ Blue Dental ☐
Blue Commercial ☐

Assigned Wellmark Group Provider Number(s) & NPI: ____________________________

Assigned Wellmark Individual Provider Number(s) & Name(s) & NPI: ____________________________

If additional space for provider numbers and names is needed, please attach a list to this agreement.

For information on communications software to submit ANSI 837 electronic transactions please contact EC Solutions at 800-407-0267.

Please complete and sign the registration form. The signature (located at the bottom of the form) must be from a provider or an office administrator authorized to sign on behalf of the doctors or facility.
Authorized Signature /Date (REQUIRED) ____________________________

Revised June 27, 2007
SIGNATURE AND AUDIT AGREEMENT

We (I) hereby authorize Wellmark Blue Cross and Blue Shield, acting on their own behalf or as fiscal agents for the administration of Title XVIII in Iowa or as agents of Blue Dental Plan and Pharmacy Service Corporation access to patients’ files to:

1) Verify that valid patient authorizations are received and maintained for claims submitted from the office, when applicable.

2) Verify the validity and accuracy of the claims submitted.

In submitting machine readable claims, WE (I) understand that WE ARE (I AM) certifying that the required patient signatures, or, where applicable, appropriate signatures on behalf of the patient, and required physician certifications and re-certifications (PSRO certifications where applicable) are on file and that anyone who misrepresents or falsifies essential claims information, may, upon conviction be subject to fine and imprisonment under Federal law.

In the event that payment information is returned in machine-readable form, WE (I) understand that this information will cover all claims paid to this provider number whether they were submitted on paper or in machine readable form.

- Patient Authorizations (signatures) are not required for non-patients.
- Please photocopy this page for each provider number you need to register.

Signed: __________________________________________________________

Provider Name: ___________________________________________________

Address 1: _________________________________________________________

Address 2: _________________________________________________________

City, State and Zip Code: ____________________________________________

Assigned Wellmark Provider Number & Name: __________________________

Assigned National Provider Identifier (NPI): __________________________

Date: __________________________________________________________________

Fax to EC Registration Department at: 800-691-1038
or mail to:
EC Solutions
Attention: EC Registration Department
636 Grand Avenue, Station 142
Des Moines, IA 50309

Revised June 27, 2007
I, ________________________________________________, ____________________________
(Administrator/Officer) (Title)
representing ____________________________________________ submitter number __________________
(Provider Office Name) (Provider Submitter # if Applicable)
authorize ________________________________ submitter number __________________
(Clearing House/Billing Service) (Clearing House/Billing Service Submitter #)
__________________________________________ to submit my electronic claims to INet
for the following provider numbers and names: ____________________________ ____________________________
__________________________________________ ____________________________ ____________________________
__________________________________________ ____________________________ ____________________________
If additional space for provider numbers and names is needed, please attach a list to this agreement.
Provider Office Name: ______________________________________________________________
Provider Address: _________________________________________________________________
City, State and Zip Code: ___________________________________________________________
Phone: ( ) __________________________ Fax: ( ) __________________________
E-mail Address: ________________________________________________________________
__________________________________________ (Signature of Administrator in Provider Office) (Signed Date)

Note: This box is only applicable if you currently receive Electronic Remittance Advices (ERA) or
would like to receive ERA’s in the future.

☐ I would like my ERA to go to my office.
The submitter number for my office is: ____________________________

OR

☐ I would like my ERA to go to my Clearing House/Billing Service.
Their submitter number is: ____________________________