ENROLLMENT FORM

PLEASE FILL IN THE INFORMATION BELOW FOR THE PERSON OR ENTITY RESPONSIBLE FOR CHARGES AND MAINTAINS OWNERSHIP AND ACCESS TO THE ACCOUNT.

Owner of Account/Practice Name:* _____

*Please Note: If this is a billing service, clearinghouse, or software vendor please enroll as such. You may enter provider information below.

OFFICE INFORMATION

Mailing Address:

Street Address:*_____

City: *_____ State: * _____ Zip: * _____

Contact Information: (Individual actually submitting claims)

First Name:*_____ Last Name:*_____

Telephone: *_____ Facsimile: *_____

Email: *_____ Title:* _____

Type of Practice:*

☐ Billing Company ☐ Solo Practice ☐ Group Practice ☐ Clearinghouse ☐ Software Vendor

Are you a member of ActivHealthCare? ☐ Yes ☐ No **The Payer ID for ActivHealthCare claims is AHCØ1.**

BILLING INFORMATION

Billing Address: ☐ Check if same as mailing address

Street Address:*_____

City: *_____ State: * _____ Zip: * _____

Billing Contact Information: ☐ Check if same as contact information in previous section

First Name:*_____ Last Name:*_____

Telephone: *_____ Facsimile: *_____

Email: *_____ Title:* _____

PROVIDER/GROUP INFORMATION

If you are enrolling as a Group complete the "Group Provider(s)" section and if any individual providers are billing under the Group NPI# then list them in the "Individual Provider(s)" section. If you are enrolling as an individual provider complete the "Individual Provider(s) section. If you need room for additional providers then print another copy of this page and submit with enrollment form.

Group Provider(s)

1	Name of Billing Provider/Group: *_____ Tax ID: *_____ Group NPI#:* _____ Specialty: *_____
2	Name of Billing Provider/Group: *_____ Tax ID: *_____ Group NPI#:* _____ Specialty: *_____
3	Name of Billing Provider/Group: *_____ Tax ID: *_____ Group NPI#:* _____ Specialty: *_____
4	Name of Billing Provider/Group: *_____ Tax ID: *_____ Group NPI#:* _____ Specialty: *_____
5	Name of Billing Provider/Group: *_____ Tax ID: *_____ Group NPI#:* _____ Specialty: *_____

Individual Provider(s)

1	First Name: *_____ Last Name:* _____ Tax ID: *_____ Individual NPI#:* _____ Specialty: *_____
2	First Name: *_____ Last Name:* _____ Tax ID: *_____ Individual NPI#:* _____ Specialty: *_____
3	First Name: *_____ Last Name:* _____ Tax ID: *_____ Individual NPI#:* _____ Specialty: *_____
4	First Name: *_____ Last Name:* _____ Tax ID: *_____ Individual NPI#:* _____ Specialty: *_____
5	First Name: *_____ Last Name:* _____ Tax ID: *_____ Individual NPI#:* _____ Specialty:*_____

SYSTEM INFORMATION*

Please tell us how you would like to submit your claims. Check ALL that apply (must select at least one)

- ☐ Undecided
- ☐ Office Ally's Practice Mate
- ☐ Office Ally's Electronic Health Records System
- ☐ Office Ally's Online Claim Entry Tool

  Forms Used: ☐ CMS 1500 ☐ UB-04 ☐ ADA
- ☐ We will be using another billing software (Please include your software information below)

  Software/Version: _____

CREDIT CARD PROCESSING UTILITY

☐ Yes, I am interested in Office Ally's integrated credit card processing. Please contact me with additional information.

Best Time to Contact: _____ Best Contact Method: _____ Promo Code: _____

Special Instruction/Alternate Contact: _____

BILLING COMPANY

☐ Yes, I am interested in Office Ally's Billing Service. Please contact me with additional information.

Best Time to Contact: _____ Best Contact Method: _____

OFFICE ALLY REPRESENTATIVE*

Please list your Office Ally Representative: _____

How did you hear about us? _____

ONEHEALTH PORT USERS

Currently enrolled OneHealth Port users check the box below, and fill in your OneHealth Port User Name.

Are you a OneHealth Port user? ☐ Yes ☐ No OneHealth Port User Name: _____

**This will become your Office Ally User Name if available*

In order to process your enrollment you must also submit a one (1) page Authorization sheet included with this form. Within 24 hours of receiving your enrollment form and authorization sheet you will receive an email containing your username and a link to create your password. Within 24 hours after this an Office Ally representative will contact you to schedule a training appointment.

AUTHORIZATION SHEET

Practice / Facility Name: _____

TERMS/CONDITIONS:

- Payer/Provider ensures that all data submitted to Office Ally is valid and represents services performed accurately.
- Office Ally shall not be deemed responsible for any claims transactions that fail due to incorrect/invalid data and all such rejections shall be the sole responsibility of the submitter for correction and resubmission. The received date of the claims shall be the date the claim is actually transmitted to the payer.
- Office Ally to automatically reprocess all claims rejected (for IPA's ONLY) due to 'Member Not Found' and "Member Not Eligible At Time of Service". Reprocessing will take place (7) days, (14) days and (21) days after the initial rejection. Provider will be notified: 1) at the time of the original rejection, and 2) at the time that the claim is accepted, or after the third attempt to reprocess at day (21) if the claim is still rejected for 'Member Not Found' or 'Member Not Eligible At Time of Service.' If the member is found to be eligible after reprocessing the date that the claim is received by payer will be the date that Office Ally actually transmits the claim to Payer.
- Certain payers require pre-enrollment which must be completed and approved before claims can be sent electronically. These payers include, but are not limited to Medicare, Medicaid/Medi-Cal, TriWest, and Blue Shield/Blue Cross, see our payer list for a complete listing.
- In an effort to provide our customers the best pricing available, Office Ally utilizes email for all correspondence, including accounting notices and invoices. It is your responsibility to ensure Office Ally has a valid email address for you at all times.

GOVERNMENT CLAIMS POLICY: IT IS YOUR RESPONSIBILITY TO ENSURE THAT ALL PRE-ENROLLMENT FORMS ARE DONE PROPERLY AND APPROVED

- I understand that if my monthly claim volume exceeds 50% governmental claims (including, but not limited to Medicare, Medi-Cal/Medicaid, DMERC, Railroad, and BCBS in some states), my account is subject to a Governmental processing fee of $19.95 per month*.
- In addition I understand that all totals are calculated per account (username) and I will only be charged this fee for months in which I exceed the 50% limit. If my Medicare/Medi-Cal/Medicaid/DMERC/Railroad/BCBS claim volume is less than 50%, I will not be charged.

Initial Here_____ to indicate that you have read and understand the above policy. Initial required regardless if applicable.

CLAIM PRINTING POLICIES:

- All claims that Office Ally is able to submit electronically are done so FREE OF CHARGE. Any claims that Office Ally has to print and mail are done so at a rate of $ 0.40 cents per page* if you select this option below.
- Claims that need to be printed and mailed to individuals (such as patients or attorneys) will be charged a rate of $0.55 per page*. The provider or biller will be invoiced monthly via email for these paper claims.

ELECT PRINTING OPTION: YOU ARE REQUIRED TO MAKE A CHOICE BELOW (CHECK ONLY ONE)

_____ Do not print any claims for me. I understand that if I transmit claims that cannot be sent electronically, they will be rejected back to me.

_____ I hereby allow Office Ally to print and mail to the appropriate payers the claims that are not accepted electronically as indicated by our payer list and your pre-enrollment status, and agree to pay Office Ally $0.40/claim* for claims sent to insurance companies/payers and $0.55/claim* for claims sent to individuals (such as patients or attorneys). User will be invoiced for paper claims monthly.

Office Ally EDI Enrollment form insert for ActivHealthCare

Initial Here_____ to indicate You Have Read and Understand the following paragraph that was included in your agreement with ActivHealthCare, Inc. and which is equally applicable under this agreement:

Office Ally will forward to Activ claim data for all claims received from Provider, except that with respect to Non-Affiliated Claims, Office Ally will delete patient name and such other data as is necessary to ensure that the data forwarded to Activ on such Non-Affiliated Claims do not constitute "protected health information" under The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and such data and actions do not otherwise contravene any applicable law. With respect to Affiliated Claims, on HCFA Form 837, Provider authorizes Activ and Office Ally to change the taxpayer identification number (box 25) from Provider to Activ and change the billing address (box 33) to Activ's designated office billing address when such changes are applicable as indicated by "Claims Filing:" address on the applicable ActivHealthCare Term Summary Sheet referenced in paragraph 2I of the Provider Agreement. Such data will be

analyzed to evaluate the effectiveness of and to manage chiropractic care and the network as well as for marketing and credentialing purposes. Any existing data analysis specific to Provider will be made available by Activ to Provider upon reasonable written request.

By signing below, you are acknowledging that you have read, understand and agree to all terms/conditions in full.

Owner of Account/President/CEO/Owner Signature	Date
Owner of Account/President/CEO/Owner Name (Please Print)	Title (Please Print)
Contact Name / Contact Phone Number	Office Ally Representative

Fax to: (770) 455-6188 or
Mail to: ActivHealthCare, Inc.
P.O. Box 1368
Lilburn, GA 30048

Questions? Call (770) 455-0040 or
Toll-free (888) 635-0459