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 Integrated-ActivHealthCare? ☐ Yes ☐ No

The Payer ID for Integrated-ActivHealthCare claims is AHCØ2.

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

Owner of Account / Practice Name*: _____

**Must match the Owner of Account / Practice Name on the Enrollment Form. The name listed here will be considered the Owner of the Office Ally Account. This field is required for the form to be processed.*

TERMS/CONDITIONS:

- Submitter 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.
- **21 Day Rule:** Office Ally will automatically reprocess all claims pended (for specific payers where Office Ally performs Patient Eligibility checking) due to '**Patient Not Found**' and '**Patient Not Covered (at time of service)**'. Reprocessing will take place on the 7th, 14th and 21st day after the initial processing. Provider will be notified: 1) at the time of the original processing that the claim is pending, and 2) at the time that the claim is accepted, or 3) after the third/last attempt to reprocess (21st day) if the claim is still rejected. If the patient is found to be eligible after reprocessing, the received date will be the date that Office Ally actually transmits the claim to Payer. This option is on by default, but can be turned off per user's request.
- **Pre-Enrollment Requirement**: Certain payers require pre-enrollment which must be completed and approved before claims can be sent electronically. See our **payer list** for a complete listing.
- **Owner of Account below agrees to be held financially responsible for all fees and/or finance charges incurred by this account**.
- 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/NON-PAR CLAIMS POLICY:

To determine whether a payer is Government/Non Par, please reference the TYP (Type) column of our Payer List. G/NP indicates a Payer is Government/Non Par, while C/P indicates a Payer is Commercial/Par.

- If my Government/Non-Par (G/NP) claim volume is greater than or equal to 50% of my total claim volume in a month, my account is subject to a processing fee of $19.95 for that month*.
- If my Government/Non-Par (G/NP) claim volume is less than 50% in a month, I will not be charged this fee for that month.
- All totals are calculated per account (Admin Username) and I will only be charged this fee for months in which I meet or exceed the 50% limit.

Initial Here* _____ to indicate that you fully understand the Government/Non-Par Claims policy. Required regardless if applicable.

CLAIM PRINTING POLICIES:

- All claims that Office Ally is able to submit electronically are transmitted FREE OF CHARGE.
- Any claims that Office Ally has to print and mail are done so at a rate of $ 0.45 cents per claim* if you select this option below.
- Claims that need to be printed and mailed to individuals (such as patients or attorneys), or to foreign countries are $0.55 per claim*.
- The submitter 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 claims that cannot be transmitted electronically as indicated on the payer list and the provider's pre-enrollment status. I agree to pay Office Ally $0.45/claim* for claims sent to insurance companies/payers and $0.55/claim* for claims sent to individuals (patients/attorneys) or to foreign countries. I further understand it is my responsibility to ensure that all pre-enrollment forms are properly completed, submitted and approved, and that Office Ally is aware of the approval. Claims I submit to payers that require pre-enrollment, where the approval has not been logged in Office Ally's system, will be printed and mailed at my expense.

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

_____ _____

Signature *(Owner of Account or President/CEO/Owner of Practice/Facility)* **Date**

_____ _____

Name *(Owner of Account or President/CEO/Owner of Practice/Facility)* **Title** *(President/CEO/Owner of Practice/Facility)*

_____ _____

Main Contact Name / Phone Number **Main Contact Email Address**

_____ _____

Training Contact Name / Phone Number *(If different then Main Contact)* **Training Contact Email Address**
(The person we should contact to set up training appointment(s) for your office.)

*Rate and Payer List are subject to change