



www.gatewayedi.com  
501 N. Broadway, 3rd Floor  
SAINT LOUIS, MISSOURI 63102  
(314) 802-6700 (800) 969-3666 FAX (314) 898-1932

## **CALIFORNIA BLUE CROSS ERA & EFT Professional or Institutional**

- A voided blank check or bank authorization letter is required for the account receiving the direct deposit. Deposit slips are NOT accepted by the payer.
- Be sure to select either Professional or Institutional for the claims you will be submitting.

Please mail all pages of the completed forms to:

Gateway EDI, a TriZetto Co.  
Provider Enrollment Dept.  
501 N. Broadway, 3rd Floor  
St. Louis, MO 63102

- Due to system or processing changes, it may be necessary for the payer to change their agreements. If this occurs during your enrollment process, you may be asked to complete an updated form.
- If the Tax ID submitted on this enrollment form is associated with more than one office, all remittances for that Tax ID regardless of who submits the claim, will be returned to that vendor.



# ERA Enrollment Form

Please Fax or E-mail Completed Forms to:  
 Fax: (804) 354-2529 / edi.ent.enroll@anthem.com  
 EDI Technical Support: (800) 227-3983  
 Incomplete or illegible enrollment packages will be returned  
 unprocessed.

Please print clearly. A separate form is required for each Tax Identification Number.

Institutional  Professional  Dental

Provider Name: Monterey County Health Department Laboratory Location code \_\_\_\_\_  
If applicable  
 Tax ID #: 946000524 NPI #: 1326125337 Medicare #: \_\_\_\_\_  
 Street Address: 1270 Natividad Road City: Salinas State: CA ZIP: 93906  
Institutional Providers Only  
 Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_  
 Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Please indicate method of retrieval for your Anthem Blue Cross Electronic Remittance Advice (ERA) file:

- We are a direct claim submitter and will download our own ERA files.  
 Our electronic mailbox ID is (ex: CA12345P) \_\_\_\_\_  
 Our ERA translation software is \_\_\_\_\_
- Please assign a new mailbox to download our own ERA files.  
 Our ERA translation software is \_\_\_\_\_
- We are switching vendors. Please discontinue our current ERA services with vendor: \_\_\_\_\_
- Our vendor will retrieve all ERA files for us. (Please have vendor complete the following fields.)

Vendor Name: Gateway EDI  
 Vendor Contact Name: ERA Enrollment  
 Vendor Contact Phone: 314/802-6700 x1526  
 Vendor Email: eraenrollment@gatewayedi.com  
 Vendor Submitter ID: CA00485C

*Note: Please be sure your vendor is set up to receive ERA files from Anthem Blue Cross.  
 We cannot process this request if they are not set up.*

**A company officer must sign this form. This is a legal document.**

PRINT  
 NAME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
 TITLE: \_\_\_\_\_ DATE: \_\_\_\_\_ PHONE: \_\_\_\_\_

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ATTACHMENT A



# EFT Enrollment Form

Please Fax or E-mail Completed Forms to:  
 Fax: (804) 354-2529 / edl.ent.enroll@anthem.com  
 EDI Technical Support: (800) 227-3983  
 Incomplete or illegible enrollment packages will be returned  
 unprocessed.

A copy of a voided check or bank authorization letter for the account receiving the direct deposit must be attached.  
**DEPOSIT SLIPS ARE NEVER ACCEPTED UNDER ANY CIRCUMSTANCES.**

<b>PROVIDER NAME</b> (REQUIRED) Monterey County Health Department Laboratory Email : _____	<b>MEDICARE PROVIDER NUMBER</b> (REQUIRED only for institutional providers)
<b>ADMINISTRATIVE CONTACT:</b> (REQUIRED)	<b>TAX ID NUMBER:</b> (REQUIRED)
<b>TITLE:</b> (REQUIRED)	<b>PHONE NUMBER:</b> (REQUIRED)

## BANK INFORMATION Bank Account Change Only

<b>NAME ON BANK ACCOUNT</b> (REQUIRED)	
<b>ACCOUNT TYPE</b> (REQUIRED) <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS	
<b>BANK NAME</b> (REQUIRED)	<b>BRANCH NAME</b> (REQUIRED)
<b>BANK ADDRESS</b> (REQUIRED)	<b>BANK PHONE NUMBER</b> (REQUIRED)
<b>ACCOUNT NUMBER</b> (REQUIRED)	<b>TRANSIT/ABA NUMBER</b> (REQUIRED)

You are authorizing Anthem Blue Cross to deposit payments for claims to the account listed above.  
 This is a legal document. *An authorized signer on the bank account must sign this form.*

**PRINT NAME:**  
 (REQUIRED) \_\_\_\_\_

**SIGNATURE:**  
 (REQUIRED) \_\_\_\_\_

**TITLE:**  
 (REQUIRED) \_\_\_\_\_

**PHONE NUMBER:**  
 (REQUIRED) \_\_\_\_\_

**DATE SIGNED:**  
 (REQUIRED) \_\_\_\_\_

**FAX NUMBER:**  
 \_\_\_\_\_

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ATTACHMENT B

IS TO FORM AND LEGALITY  
 LEGALITY  
 DEPUTY COUNTY COUNSEL  
 COUNTY OF MONTEREY

