

CONTRACT APPROVAL FORM

(Contract Management Use only)

CONTRACT TRACKING NO.
CM2366

CONTRACTOR INFORMATION

Name: Blue Cross Blue Shield of Georgia

Address: 3350 Peachtree Road, N.E. Atlanta GA 30326
City State Zip

Contractor's Administrator Name: Customer Service Title: Online registration

Tel#: (855) 397-9267 Fax: _____ Email: https://www.bcbsga.com/home-providers.html

CONTRACT INFORMATION

Contract Name: Blue Cross Blue Shield of Georgia Provider Access Agreement Contract Value: N/A

Brief Description: Required on-line access to obtain remittance advices for Rescue billing payments that are processed through electronic funds transfers. The agreement is processed on-line. On-line access will be effective until canceled.

Contract Dates : From: Sign to: Indefinite Status: New Renew Amend# WA/Task Order

How Procured: Sole Source Single Source ITB RFP RFQ Coop. Other On-line system access only

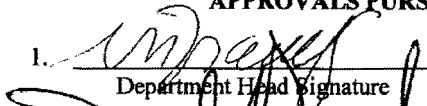
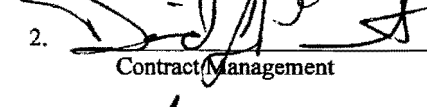
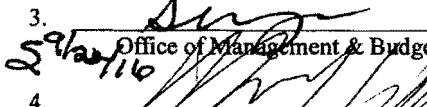
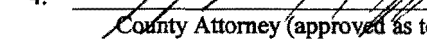
If Processing an Amendment:

Contract #: _____ Increase Amount of Existing Contract: _____

New Contract Dates: _____ to _____ TOTAL OR AMENDMENT AMOUNT: _____

APPROVALS PURSUANT TO NASSAU COUNTY PURCHASING POLICY, SECTION 6

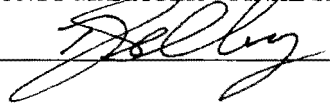
SEP 26 AM 8:35

1.  9-21-16
Department Head Signature Date
2.  9/21/16
Contract/Management Date
3.  9-22-16
Office of Management & Budget Date
4.  9-21-16
County Attorney (approved as to form only) Date

Submitting Department _____
Funding Source/Acct # N/A

Comments: _____

COUNTY MANAGER - FINAL SIGNATURE APPROVAL

 9/26/16
Ted Selby Date

RETURN ORIGINAL(S) TO CONTRACT MANAGEMENT FOR DISTRIBUTION AS FOLLOWS:

- Original: Clerk's Services; Contractor (original or certified copy)
- Copy: Department
- Office of Management & Budget
- Contract Management
- Clerk Finance

David Pensante

From: Margie Drawdy
Sent: Wednesday, September 21, 2016 1:35 PM
To: David Pensante
Subject: BCBS OF GEORGIA AGREEMENT
Attachments: BCBS OF GA WEB PORTAL AGREEMENT.pdf

David

I am trying to obtain access to the Blue Cross and Blue Shield of Georgia web portal. I need access to obtain remittance advices for Rescue billing payments that are processed through electronic funds transfers. The agreement is processed online and I have attached copies of the pages.

I talked with Shanea and she advised that Ted is the only person that has the authority to sign for the county. She suggested setting up as a contract and having him complete the attached information. Someone else can go online and complete the form for him.

Let me know is you have any questions.

Thanks!

Margie

Margie Drawdy
Billing Supervisor
Office of Management & Budget
Nassau County Board Of County Commissioners
904.530.6030, Office
904.491.7372, Fax
mdrawdy@nassaucountyfl.com

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[Login](#) / Tax ID Number Authorization

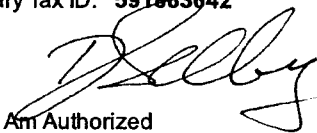
Tax ID Number Authorization

Please authorize that you can make binding agreements on behalf of your organization.

Based on the tax identification number you provided, our records indicate that your organization does not have a ProviderAccess agreement.

Are you in a position with your organization to make binding agreements on behalf of your organization? Typically, individuals with the following titles are authorized to sign the ProviderAccess Agreement: Administrator, Director, Physician, Office Management, Vice President, or President.

Primary Tax ID: **591863042**

I Am Authorized 

Indicates a Required Field

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[Login / Registration Form](#)
Registration Form

Registration Information

First Name	<input type="text"/>	Business Name	NASSAU COUNTY BOARD OF COUNTY
Last Name	<input type="text"/>	Address 1	76347 VETERANS WAY STE 4100
Your Title	None Selected ▼	Address 2	
Your Phone (999-999-9999)	<input type="text"/>	City	YULEE
Your Extension	<input type="text"/>	State	FL
Your Fax (999-999-9999)	<input type="text"/>	Zip	32097
Your Email	<input type="text"/>		

Note: The email address must be a valid email account.

Primary Tax ID **591863042 002**

Login Information

Create User ID (abcdef123)	<input type="text"/>	Secret Question	None Selected ▼
		Secret Question Answer	<input type="text"/>

Note: You will be asked for the answer of your secret question should you forget your password..

Indicates a Required Field

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[Login / Agreement](#)

Agreement

Account Agreement Form

Blue Cross Blue Shield of Georgia ProviderAccess Agreement

I, Theodore S Selby, (Physician/Healthcare Professional/Healthcare Institution) hereby asked to participate in the ProviderAccess Program operated by Blue Cross Blue Shield of Georgia and its affiliates ("Blue Cross Blue Shield") through the Blue Cross Blue Shield of Georgia internet website and whereby Physician/Healthcare Professional/Healthcare Institution may have access to various eligibility, claim and benefit information about persons having medical coverage through Blue Cross Blue Shield of Georgia. As a condition of participating in ProviderAccess, Physician/Healthcare Professional/Healthcare Institution agrees to the following:

- Physician/Healthcare Professional/Healthcare Institution and office staff will request information only for new and existing patients and will use such information only in connection with the performance of medical treatment or services.
- Physician/Healthcare Professional/Healthcare Institution will assure appropriate use of ProviderAccess by employees and agents and will implement appropriate procedures to assure such appropriate use and to preserve the confidentiality of information available through ProviderAccess. As part of such office procedures, Physician/Healthcare Professional/Healthcare Institution will assure that when any employee or agent who may have had access to ProviderAccess leaves the employ of Physician/Healthcare Professional/Healthcare Institution, the access code (PIN) used by Physician/Healthcare Professional/Healthcare Institution for ProviderAccess will be changed.
- Physician/Healthcare Professional/Healthcare Institution will designate an Account Administrator who shall control access by subordinate users authorized by Physician/Healthcare Professional/Healthcare Institution to use ProviderAccess under Physician/Healthcare Professional/Healthcare Institution's taxpayer identification number as Physician/Healthcare Professional/Healthcare Institution's agent. The Account Administrator shall establish password controlled access for each such subordinate user in accordance with the instructions of Blue Cross Blue Shield of Georgia and shall assure that such access is promptly terminated should a subordinate user no longer be authorized by the Physician/Healthcare Professional/Healthcare Institution to have such access. The Account Administrator shall establish that any subordinate user license number is valid for that subordinate user.
- Physician/Healthcare Professional/Healthcare Institution warrants that subordinate users shall be authorized only to the extent necessary to perform their functions on behalf of Physician/Healthcare Professional/Healthcare Institution, each subordinate user shall be held to the same standard of confidentiality applicable to the Physician/Healthcare Professional/Healthcare Institution, and that the Physician/Healthcare Professional/Healthcare Institution shall be responsible for use of ProviderAccess by any such subordinate user.
- Physician/Healthcare Professional/Healthcare Institution understands that information available through ProviderAccess is confidential, Physician/Healthcare Professional/Healthcare Institution agrees to preserve such information as confidential in accordance with law. Physician/Healthcare Professional/Healthcare Institution will indemnify and hold Blue Cross Blue Shield of Georgia harmless from any loss or damage resulting from the unauthorized use or disclosure of information obtained by Physician/Healthcare Professional/Healthcare Institution or their employees or agents through ProviderAccess.
- Physician/Healthcare Professional/Healthcare Institution is a covered Entity for the purposes of the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-164) relating to the confidentiality and data security of medical information, and Physician/Healthcare Professional/Healthcare Institution shall be and remain in compliance therewith.

By clicking "I Accept" I understand that I am entering into a legally binding contract and that I am assuming obligations under that contract and that I may have liability if I fail to perform these obligations. By clicking "I Accept" I intend to enter into that contract and assume these obligations. I understand that I should print a copy of this screen for my records.

- I do NOT accept
- I accept Online

 9/26/16

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