
**ANSI 4010A1 276 / 277 CLAIM STATUS INQUIRY
ENROLLEE INFORMATION**

The following pages should be completed to begin your enrollment for the electronic transmission of ANSI 4010A1 276/277 Claim Status Inquiry or to update your current EDI profile for Claim Status Inquiry. Questions should be directed to the EDI Service Line at 501-378-2419 or toll free at 866-582-3247.

Provider's Submitter Number (write "NEW" if new enrollee): _____

Provider's Name: _____

Provider's Pay-to Arkansas BlueCross BlueShield Provider Number: _____

Submitter's Address: _____

City _____ State _____ Zip Code _____

Contact Person: _____

Telephone # _____ Fax # _____

E-mail Address _____

TRANSMISSION INFORMATION

➤ *Submitter plans to transmit 276 Claim Status Inquiry for providers in Arkansas.*

Arkansas Blue Cross Blue Shield – Arkansas Providers Only

Includes Blue Cross and Blue Shield, Health Advantage, and BlueAdvantage (USABLE) Administrators, Blue Card (ITS), Medipak, and Federal Employees Program (FEP).

➤ *Submitter will be using the following vendor to transmit 276 Claim Status Inquiry*

_____ Directly from facility to the EDI Services System

_____ Through a Clearinghouse – Submitter ID of Clearinghouse: _____

_____ Other Vendor: _____

Submitter ID of "Other Vendor": _____

An original signature is required from the Provider, CEO, CFO, COO or other duly authorized senior officer of Facility/Clinic/Clearinghouse/Billing Agent. Submitter agrees to send only transactions for Arkansas BlueCross BlueShield valid providers!

Provider's Signature: _____

Date: _____

LETTER OF AUTHORIZATION - 276 / 277

**Network Service Access of Arkansas BlueCross BlueShield Systems
TO BE SIGNED BY PROVIDER**

Please complete the form below and return by mail or fax to the address/number located at the bottom of this page. A Letter of Authorization should be returned for each pay-to provider listed in the "Provider Information" section of this enrollment.

This document is for the purpose of authorizing someone other than the Provider to access Arkansas BlueCross BlueShield Systems on the Provider's behalf. All fields must be completed, and failure to include all necessary information may result in the rejection of this letter. An original signature is required from the Provider, CEO, CFO, COO or other duly authorized senior officer of Facility/Clinic.

Provider or Facility Name	
Provider or Group Number	
Provider Submitter Number	

Vendor Name	
Vendor Submitter Number	
Effective Date	

Select the date you want to begin submitting claim status inquiries through this clearinghouse. Please be prepared to make your changes on the date you have indicated.

Please note that this Authorization Form applies to 276/277 transactions only. Submitting this form will not effect the provider's set-up for claim-submission, ERA, or any other EDI transaction.

By my signature below, I authorize the above named Vendor to access Arkansas BlueCross BlueShield Systems on behalf of the above named Provider.

Signature

Printed Name

Title

Date

**EDI 4-South
601 S. Gaines St.
Little Rock, AR 72203
Fax – (501) 378-2265**