
ENROLLMENT INSTRUCTIONS

Thank you for your interest in Electronic Data Interchange for the Arkansas Blue Cross Blue Shield 270/271 Eligibility Inquiry and Response; 276/277 Claim Status and Response; 820 Group Payment; or 834 Benefit Enrollment transactions. {Note: This is for Arkansas Blue Cross Blue Shield only and all transactions below include Blue Cross, Blue Shield, Health Advantage, BlueAdvantage (USAb) Administrators, Blue Card (ITS), Medipak, and Federal Employees Program (FEP)}

- ü Vendors, Clearinghouses and Providers, who will transmit the above transactions and do not have a submitter number, must complete an Arkansas Blue Cross Blue Shield Trading Partner Agreement.
- ü In addition, vendors who will only transmit the 820 or 834 are required to have a Business Associate Agreement on file with Arkansas Blue Cross Blue Shield.
- ü Arkansas Blue Cross Blue Shield customers who will use a vendor for the 820 or 834 are not required to have a submitter number.

Attached is the enrollment packet. If you have questions or need assistance in completing this form, please feel free to contact EDI Services enrollment at 501-378-2419.

Provider/Customer Information

Enter the provider's pay-to provider number which is the group/clinic provider number assigned by ABCBS provider enrollment. The pay-to provider number can be located in the upper right corner of a provider's Explanation of Benefits (EOB).

OR

Enter the ABCBS customer's group ID or contract number assigned by ABCBS for 820/834 transactions.

Clearinghouse/Vendor Information

Please be sure to include the Clearinghouse/Vendor email address. Once EDI Services has approved your enrollment, you will be notified by **email** that you may begin sending that transaction for your client.

Letter of Authorization

The authorization form must be completed with the original signature of the provider, ABCBS customer, CEO, CFO, COO of the clinic/group. This form cannot be signed by an office manager, clinic manager, billing agent or billing personnel.

Processing Time

Once the form has been received by EDI Services, under normal working conditions, it will be processed within three to five business days. The clearinghouse/vendor will be notified by email when the setup has been completed. Providers/ABCBS Customers will be notified by letter.

ENROLLMENT INFORMATION

270/271 Eligibility Inquiry and Response 820 Group Payment
276/277 Claim Status and Response 834 Benefit Enrollment

Questions about this form should be directed to EDI Services enrollment at 501-378-2419.

Ø ABCBS Provider/Customer Information:

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

Provider/Customer Name: _____

Provider's Pay-to Provider Number or NPI number/Customer's Group/Contract ID: _____

Mailing Address: _____

City _____ State _____ Zip Code _____

Contact Person: _____

Telephone # _____ Fax # _____

E-mail Address _____

Ø Clearinghouse/Vendor Information:

Clearinghouse/Vendor Name: _____

Mailing Address: _____

City _____ State _____ Zip Code _____

Contact Person: _____

Telephone # _____ Fax # _____

E-mail Address _____

Ø Transaction Information:

Submitter plans to transmit the following transaction for ABCBS provider/customer {Note: This is for Arkansas Blue Cross Blue Shield only and all transactions below include Blue Cross, Blue Shield, Health Advantage, Blue Advantage (USAb) Administrators, Blue Card (ITS), Medipak, and Federal Employees Program (FEP).} Please check all that apply:

- | | |
|---|---|
| <ul style="list-style-type: none">• 820 Group Payment• 270/271 Eligibility Inquiry and Response• 276/277 – Claim Status and Response | <ul style="list-style-type: none">• 834 Benefit Enrollment ANSI _____ Flat File _____ Supplemental _____ Proprietary _____ |
|---|---|

Ø Submitter will transmit the above transaction selected above (choose one):

- _____ Directly from facility to the EDI Services System
- _____ Through a Clearinghouse – Clearinghouse's Submitter ID: _____
- _____ Other Vendor - Vendor's Submitter ID: _____

LETTER OF AUTHORIZATION

**Network Service Access of Arkansas Blue Cross & Blue Shield Systems
TO BE SIGNED BY PROVIDER/CUSTOMER**

Please complete the form below and return by mail or fax. Return information is provided at the bottom of this page . An original signature is required from the Provider, CEO, CFO, COO or other duly authorized senior officer of Facility/Clinic.

This document is for the purpose of authorizing someone other than the Provider/Customer to access Arkansas Blue Cross & Blue Shield Systems on the Provider's/Customer's behalf. All fields must be completed, and failure to include all necessary information may result in the rejection of this letter.

Provider/Customer Name	
Provider's Group Number; NPI # or Customer's Group/Contract ID	
Provider Submitter Number	

CH/Vendor Name	
CH/Vendor Submitter Number	
Effective Date	

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

Submitting this form will not effect the provider's set-up for claim submission or ERAs.

By my signature below, I authorize the above named Clearinghouse/Vendor to access Arkansas Blue Cross & Blue Shield Systems on behalf of the above named Provider/Customer.

Signature

Printed Name

Title

Date

**Return to:
EDI 4-South
601 S. Gaines St.
Little Rock, AR 72201
Fax: 501-378-2265**