



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms.  
7/25/2011 (NF, IE)

<http://www.arkansasbluecross.com/providers/edi.aspx>

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## **BCBS - ARKANSAS 270/271- ELIGIBILITY Enrollment Instructions**

- ✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record added.** Please contact your EDI solutions reseller to confirm your EDI account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck provider numbers to be sure they are valid and accurate. Invalid or incorrect provider IDs will cause the enrollment to be delayed or rejected.
- ✓ **Keep a copy of the completed enrollment pages.** Note the date and method of submission. Keep a copy of the completed request in case you should need to follow up or resubmit.

**FAX COMPLETED ENROLLMENT FORM TO-**  
Practice Insight, Enrollment Department  
713-333-0138

### **270/271 – Eligibility Transactions**

#### **1. EDI Enrollment for Arkansas Blue Cross (1 page)**

Enter Billing Provider Information.  
Enter Provider's BS AR Submitter #. (For example: E0123)  
Signature is required by Provider or authorized Clinic or Hospital Administrator.

Section – 837 Claims Transmission Information is Not Applicable.

NOTE: Provider will receive confirmation from BS AR to submit eligibility.

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### **ALLOW 2-4 WEEKS FOR PROCESSING**

*If you do not receive confirmation within 15 business days, you can call EDI Services at 1-866-582-3247 or send email addressed to [edi\\_enrollment@arkbluecross.com](mailto:edi_enrollment@arkbluecross.com) .*



**Signature:**

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

\_\_\_\_\_  
Provider/Facility Name

\_\_\_\_\_  
Provider's Submitter # (if currently set up with EDI and making changes)

\_\_\_\_\_  
Provider's Signature (must be signed by the Provider, Clinic Administrator or Hospital Administrator)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed Name of the Above Signer

\_\_\_\_\_  
Date

**Check line of business you want to bill:**

- Private Business Institutional
- FEP ONLY Dental claims
- Private Business Professional

\_\_\_\_\_  
Group/ Pay-to NPI #

\_\_\_\_\_  
Group/ Pay-to Provider #

\_\_\_\_\_  
Provider's TAX ID #

\_\_\_\_\_  
Contact Person(s)

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Fax #

\_\_\_\_\_  
Email

**Please let us know who will be picking up or sending the following transaction for you:**

- Requesting 835 Electronic Remittance Advices.** Please indicate the Submitter # picking up your electronic remittances: \_\_\_\_\_
- Requesting real time 270/271 Eligibility Inquiry & Response.** Indicate the Submitter # sending 270/271 transactions: \_\_\_\_\_  
(Before requesting, verify that your software vendor and/or practice management software can generate and produce this transaction)
- Requesting real time 276/277 Claim Status Request & Response.** Indicate the Submitter # sending 276/277 transactions: \_\_\_\_\_  
(Before requesting, verify that your software vendor and/or practice management software can generate and produce this transaction)

**837 CLAIMS TRANSMISSION INFORMATION: (ONLY CHECK ONE BOX)**

- By checking this box, you are authorizing a Third Party/Clearinghouse/Billing Agency to send on your behalf.**

\*\*\*\*\*Please supply the complete name and Submitter Number of the Clearinghouse/Billing Agency\*\*\*\*\*

Name: \_\_\_\_\_ Submitter Number: \_\_\_\_\_

- I will be sending directly from my facility using AHIN Direct Data Entry (AHIN DDE)**
- I will be sending directly from my facility to using dial up Gateway  or dial up FTP  (See our User Guide for details)**

\*\*\*\*If you are a new direct submitter you will need to complete your vendor information below or provide the Vendor Code\*\*\*\*

\_\_\_\_\_  
Software Vendor Name

\_\_\_\_\_  
Vendor Code (contact your software vendor for their Vendor Code)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Contact (printed Name)

\_\_\_\_\_  
Contact Email

\_\_\_\_\_  
Contact Phone # (include extension)

\_\_\_\_\_  
Contact Fax #

Please fax, mail, or email this completed agreement to the address or fax number below. To check on enrollment status you can email us at [edi\\_enrollment@arkbluecross.com](mailto:edi_enrollment@arkbluecross.com). Please allow 7 business days before asking for enrollment status.

**RETURN ADDRESS:**

EDJ Services -4BC/S  
PO Box 2181 Little Rock, AR 72203-2181  
FedEx or UPS: 601 S. Gaines St. Little Rock, AR 72201  
Service Line (501) 378-2419 Fax (501) 378-2265  
Email [edi\\_enrollment@arkbluecross.com](mailto:edi_enrollment@arkbluecross.com)