



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms.
8/19/2011 (IE,FE)

BCBS - WYOMING 270/271- ELIGIBILITY Enrollment Instructions

- ✓ **Make sure all required information is complete and accurate.** Invalid incorrect data will cause the enrollment to be delayed or rejected.
- ✓ **Keep a copy of the completed enrollment pages.** Note the date the forms were submitted. Keep a copy of the completed form in case you should need to follow up on your request.

FAX COMPLETED FORMS TO-
Practice Insight, Enrollment Department
713-333-0138

270/271 – Eligibility Transactions

1. **270/271 Health Care Eligibility Benefit Inquiry and Response** (2 pages)

****PLEASE COMPLETE ONE FORM FOR EACH PROVIDER/NPI DESIRING
BCBS WYOMING ELIGIBILITY ENROLLMENT****

- Page 1 - Complete using the Billing Provider's information.
- Page 2 - Enter Facility Information for billing provider.
See bottom of page--Provider's printed name, signature, title and date required.

ALLOW 2-4 WEEKS FOR PROCESSING

If it has been over 30 days since your request was mailed, and you have not received confirmation from BCBS Wyoming, contact your EDI Solutions Reseller or Support Vendor. Resellers may contact Practice Insight, Enrollment Department.

Exhibit A

270/271 Health Care Eligibility Benefit Inquiry and Response (Real-Time)

<p>270/271 HEALTH CARE ELIGIBILITY BENEFIT INQUIRY AND RESPONSE (Real-Time) FORM Version 4010A1</p>	<p>Phone number: (800) 967-7902 Fax number: (877) 269-1472 Contact us via e-mail at: support@edissweb.com Visit our website at: www.edissweb.com</p>
<p>EDI Support Services PO Box 6729 Fargo, ND 58108-6729</p>	

The information you provide on this EDI registration is used to set your facility up for the electronic 270/271 Real-time Health Care Eligibility Benefit Inquiry and Response (Real-Time) transaction. **Print legibly and complete every section as accurately as possible.** If a section is not applicable, write "N/A". If you have any questions concerning the correct completion of the form, please contact us for assistance.

INTENTIONS

1. Check the appropriate box to indicate if this is a new registration form or an update to a previously submitted registration form. *(check only one)*
 - This is a new registration form. EDISS has not received a 270/271 registration from this organization.
 - This is an updated registration form. EDISS has received a 270/271 registration from this organization, but this organization wishes to update information.

PROVIDER INFORMATION

2. What date would you like to begin the Health Care Eligibility Benefit Inquiry and Response transactions?
_____/_____/_____
3. Federal Tax ID: _____
4. Select all lines of business that apply. Fill in the blank with the appropriate billing provider number or clinic number. **Note: Separate 270/271 registration forms for Institutional and Professional LOB are required if requesting BOTH Institutional and Professional 270/271 transactions.**

Professional Lines of Business

Blue Shield *(check only one state)*
 ND WY NPI #: _____

Institutional Lines of Business

Blue Cross *(check only one state)*
 ND WY NPI #: _____

Exhibit A

270/271 Health Care Eligibility Benefit Inquiry and Response (Real-Time)

FACILITY INFORMATION

5. Please fill in the facility information for the provider/clinic that will be inquiring on the benefit eligibility.

Name: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Physical Address: _____

City: _____ **State:** _____ **Zip:** _____

Contact: _____

Telephone: () _____ ***Fax:** () _____

E-Mail: _____

*By providing your fax number, you are consenting that your fax machine is located in a secure area that is not accessible by anyone who is not authorized to view confidential information.

Entity Sending/Receiving - Indicate the entity that will be sending the 270 Health Care Eligibility Benefit Inquiry and receiving the 271 Health Care Eligibility Benefit Response. (check one)

Billing Service Clearinghouse Provider (self)

Entity Name: _____

SIGNATURE

6. The completed form with an authorized signature may be either mailed or faxed to EDISS.

As a member of this organization, I have the authority to enter into, administrate, and/or terminate contracts and make related determinations. By signing this document I verify I meet the signature requirements and authorize the set-up noted above for the 270/271 Health Care Eligibility Benefit Inquiry and Response (Real-Time) transaction.

Signature: _____

Print name: _____

Title: _____

Date: _____ / _____ / _____

