ANSI 4010A1 837 HEALTH CARE CLAIM ENROLLEE INFORMATION

The following pages should be completed to begin your enrollment for the electronic transmission of claims or to update your current EDI profile. Questions should be directed to the EDI Service Line at 866-582-3247.

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

Provider's Clinic or Association Name: ____

Provider's/Submitter's Street Address: ____

City ______________________ State _________________ Zip Code ______________________

Mailing Address if Different: ____

City ________________________ State _________________ Zip Code ______________________

Contact Persons in Provider's Office (may have up to three):____________________________________

____

Telephone # ______________________________ Fax # ___________________________________

E-mail Address ____

TRANSMISSION INFORMATION

- *Submitter is requesting to transmit as*

Physician ______ Hospital ______ Other____________________

If Physician, what is Physician's Specialty: ________________________________

- *Submitter plans to transmit the following claim transactions*

ANSI 837 Private Business Professional _______ ANSI 837 Private Business Institutional _______

- *Submitter plans to transmit claims (please check one)*

_____ Directly from facility to the EDI Services System using Asynchronous Communications

_____ Through a Clearinghouse/Billing Agent – Submitter ID ______________________

PAY-TO / GROUP PROVIDER INFORMATION

LIST PAY-TO PROVIDERS INCLUDED IN THIS ENROLLMENT

- Please do not include any provider numbers that will not be transmitted (i.e. do not include an individual provider number if that provider's claims will be transmitted under a group provider number)

Provider Name	Private Business Institutional Provider Number	Private Business Professional Provider Number	Tax ID Number	Does provider pick-up ERA's o have an AHIN workstation?

CLEARINGHOUSE/BILLING AGENT INFORMATION

Complete this section only if the Provider chooses to utilize a billing agent or clearinghouse to transmit claims X12N transaction sets.

Clearinghouse/Billing Agent Company Name: ______________________________

Clearinghouse/Billing Agent's Submitter ID: ______________________________

Representative/Contact Name: ______________________________

Address: ______________________________

City, State, Zip Code: ______________________________

Telephone #: ________________ Extension ________ Fax #: ________________

E-mail Address: ______________________________

L E T T E R   O F   A U T H O R I Z A T I O N

TO BE COMPLETED BY PROVIDER

Please complete the form below and return by mail to the address located at the bottom of this page or fax to (501) 378-2265.

This document is for the purpose of authorizing someone other than the Provider to access Arkansas Blue Cross Blue Shield EDI 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	

Billing Agent or Clearinghouse Name	
Billing Agent or Clearinghouse Submitter Number	
Effective Date	

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

By my signature below, I authorize the above named Billing Agent or Clearinghouse to access Arkansas Blue Cross Blue Shield EDI Systems on behalf of the above named Provider.

______________________________ ______________________________
Signature Printed Name

______________________________ ______________________________
Title Date

E D I   E N R O L L M E N T   F O R M

Below is the EDI agreement, which is a required component of the entire enrollment packet for a provider submitting claims electronically to Arkansas Blue Cross Blue Shield Systems. This form should be returned for each pay-to-provider number listed in the "Pay-To / Group Information" section of this enrollment.

The Provider agrees to the following provisions for submitting Arkansas Blue Cross Blue Shield (ABCBS) Private Business claims electronically.

A. **The Provider Agrees**

1. That it will be responsible for all Private Business claims submitted to EDI Services by itself, its employees, or its agents.

2. That it will not disclose any information concerning an ABCBS member to any other person or organization, except ABCBS and/or its affiliates, without the express written permission of the ABCBS member or his/her parent or legal guardian, or where required for the care and treatment of an ABCBS member who is unable to provide written consent, or to bill insurance primary or supplementary, or is required by State or Federal Law.

3. That it will submit claims only on behalf of those ABCBS members who have given their written authorization to do so, and to certify that required member signatures, or legally authorized signatures on behalf of members, are on file.

4. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:
   - Member's name,
   - Member's health insurance claim number,
   - Date(s) of service,
   - Diagnosis/nature of illness, and
   - Procedure/service performed.

5. That ABCBS has the right to audit and confirm information submitted by the Provider and shall have access to all original source documents and medical records related to the Provider's submissions, including the member's authorization and signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted.

6. That it will ensure that all claims for ABCBS or ABCBS affiliates primary payment have been developed for other insurance involvement and that ABCBS or the ABCBS affiliate is the primary payer.

7. That it will submit claims that are accurate, complete, and truthful.

8. That it will retain all original source documentation and medical records pertaining to any such particular ABCBS claim for a period of at least 6 years, 3 months after the bill is paid.

9. That it will affix the ABCBS-assigned unique identifier number and/or the National Provider Identification (NPI) number of the Provider on each claim electronically transmitted to ABCBS.

10. That the ABCBS-assigned unique identifier number and/or the NPI number constitutes the Provider's legal electronic signature and constitutes an assurance by the Provider that services were performed as billed.

11. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all member-specific data from improper access.

12. That it will establish and maintain procedures and controls so that information concerning ABCBS members, or any information obtained from ABCBS or its affiliates, shall not be used by agents, officers, or employees of the billing service.

13. That it will research and correct claim discrepancies.

14. That it will notify ABCBS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. **Arkansas Blue Cross Blue Shield Agrees To**:

1. Transmit to the Provider an acknowledgement of claim receipt.

2. Affix the ABCBS Interchange Sender Identification Number, as its electronic signature, on each electronic remittance advice sent to the Provider.

3. Ensure that payments to Providers are timely.

4. Ensure that all electronic submitters have equal access to any EDI services that ABCBS offers. Equal access will be granted to any services ABCBS sells directly, indirectly, or by arrangement.

5. Notify the Provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:

This document shall become effective when signed by the Provider. The responsibilities and obligations contained in this document will remain in effect as long as Arkansas Blue Cross Blue Shield Private Business claims are submitted to EDI Services. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. **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's Name	Provider’s ABCBS Pay-to Provider Number
______________________	______________________
Provider's Title	Provider’s Facility Name
______________________	______________________
Provider’s Physical Address	City, State, Zip
______________________	______________________
Signature	Title
______________________	______________________
Printed Name of Above Signer	Daytime Telephone Number

RETURN TO:
EDI-4BCS
PO BOX 2181
LITTLE ROCK, AR 72203
OR FAX TO (501) 378-2265