Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

IMPORTANT

All Eligibility changes must be made using Blues Enroll, BluePrint for Employers, other electronic vendor, or paper enrollment/change forms. This form is only used to adjust your payment amount for this current bill.

Month_____

Group Name_____ **Division#** _____

Address_____

Telephone _____ **Email Address** _____

☐ **Indicate if Change in Group Information**

P.O. Box 2181
Little Rock, AR
72203-2181
arkansasbluecross.com

Division Number	Action Code	Subscriber ID	Subscriber Name	Effect Date M / D / Y (for adds & changes only)	TERM Date M / D / Y (for terminations only)	Contract Type	DEDUCT From Bill	ADD To Bill	Net Change

Action Code:
A = Add Member
D = Cancel Coverage
C = Change in Contract type

Contract Type:
EE = Employee Only
ES = Employee/Spouse
EC = Employee/Children
FM = Family

Please attach this Adjustment Form to the Arkansas Blue Cross bill for the month that is being paid

Please Note: This is the preferred method for submitting adjustments to your bill

Group Administrator Name _____ **Signature** _____

BILL-ADJ 09/18

Billing Adjustments Only