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# Arkansas Provider Enrollment Packet

## GUIDELINES

### Claims Transmission

Attached is the **EDI Provider Enrollment Packet**. This enrollment packet will set up a provider to transmit Medicare and/or Arkansas Blue Cross claims electronically using a clearinghouse or billing agent. The guidelines below will assist you in completing this form successfully. Failure to include all necessary information may result in the rejection of this form. Questions should be directed to the EDI Service Line at 866-582-3247.

- ✓ **Provider's Submitter Number:** All Arkansas providers who currently send claims electronically will have their own submitter number, i.e. e9999. If you do not have a submitter number, please indicate "New." Do not use the clearinghouse's or billing agent's submitter number where it asks for provider's submitter number. If "New," a submitter number will be issued by EDI Services to the provider.
- ✓ **Provider's Name:** If you are enrolling a group/clinic, use the group provider name associated with the group/clinic pay-to provider number as filed with Medicare/Arkansas Blue Cross. If you are enrolling an individual provider, use the individual's name associated with their pay-to provider number as filed with Medicare/Arkansas Blue Cross.
- ✓ **Provider's Pay-to Provider Number:** Please indicate pay-to provider number(s) only. If that provider's claims will be transmitted under a group provider number, a list of those providers attached to the group number is not needed. Hint: Look at a recent Remittance Advice (Explanation of Benefits/EOB) and in the top right corner is the provider number that Medicare is using to pay claims.
- ✓ **Provider's Pay-to NPI Number:** Please indicate pay-to NPI number(s) only. If that provider's claims will be transmitted under a group NPI number, a list of those providers attached to the group is not needed.
- ✓ **Claim transactions:** Indicate by marking and "X" whether you will be transmitting Medicare and/or Arkansas Blue Cross claims. Private Business means all Arkansas Blue Cross products. A hint to distinguish between professional and institutional is equate "professional" as HCFA 1500 claims and "institutional" as UB92 claims.
- ✓ **Clearinghouse/Billing Agent's Submitter Number:** Each clearinghouse and/or billing agent, who is authorized to transmit claims to Arkansas Blue Cross Blue Shield, will have their own submitter number, i.e. e9999. This is different than the provider's submitter number. Please contact the clearinghouse/billing agent for their submitter number.
- ✓ **Signatures:** An original signature is required from the Provider, or authorized person on the Provider's behalf. An authorized signature is one who can sign legal documents on behalf of the Provider. Signatures from billing services or clearinghouses are not accepted.

**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 Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address if Different: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Contact Person in Provider's Office: \_\_\_\_\_

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

E-mail Address \_\_\_\_\_

**TRANSMISSION INFORMATION**

➤ *Submitter is requesting to transmit as:* Physician  Hospital \_\_\_\_\_ Other \_\_\_\_\_

➤ *Submitter plans to transmit the following claim transactions:*

ANSI 837 Medicare Professional  ANSI 837 Medicare Institutional \_\_\_\_\_

ANSI 837 Private Business Professional  ANSI 837 Private Business Institutional \_\_\_\_\_

➤ *Submitter plans to transmit claims:*

Through a Clearinghouse/Billing Agent – Submitter ID E6000

**PAY-TO / GROUP PROVIDER INFORMATION**

Please do not include an individual provider number if that provider's claims will be transmitted under a group provider number

Provider Name	Medicare Provider Number	Private Business Provider Number	Tax ID Number	NPI Number

**LETTER OF AUTHORIZATION  
TO BE COMPLETED BY PROVIDER**

Please complete the form below and return by mail to the address located at the bottom of this page. Faxed copies will be accepted.

This document is for the purpose of authorizing someone other than the Provider to submit or receive electronic data interchange (EDI) transactions on behalf of the Provider. 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, or authorized person on the Provider's behalf. An authorized signature is one who can sign legal documents on behalf of the Provider. Signatures from billing services or clearinghouses are not accepted.**

Provider or Facility Name:	
Group PTAN/Pay-to Provider Number:	
Group/Pay-to NPI Number:	
Provider Submitter Number:	

Billing Agent or Clearinghouse Name:	Medavant
Billing Agent or Clearinghouse Submitter Number:	E6000
Effective Date:	

*Select the date you want to begin submitting your claims through the billing agent or 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 submit or receive electronic data interchange (EDI) transactions on behalf of the above named Provider.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

RETURN TO: EDI-4BCS  
PO Box 2181  
Little Rock, AR 72203-2181  
FedEx or UPS: 601 S. Gaines St. Little Rock, AR 72201  
Fax (501) 378-2265  
EDI Service Line (866) 582-3247  
[edi@arkbluecross.com](mailto:edi@arkbluecross.com)

## EDI AGREEMENT



Below is the EDI Agreement, which is a required component of the entire enrollment packet for a provider submitting claims electronically, as stipulated by the Centers for Medicare and Medicaid Services.

A. The Provider agrees to the following provisions for submitting Medicare claims electronically to **CMS or to CMS's carriers, MACs or FIs**:

1. That it will be responsible for all Medicare claims submitted to CMS or a designated CMS contractor by itself, its employees, or its agents.
2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its carriers, MACs, FIs or another contractor if so designated by CMS, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.
3. That it will submit claims only on behalf of those Medicare beneficiaries who have given their written authorization to do so, and to certify that required beneficiary signatures, or legally authorized signatures on behalf of beneficiaries, 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:

Beneficiary's name	Diagnosis/nature of illness
Beneficiary's health insurance claim number	Procedure/service Performed
Date(s) of service	

5. That the Secretary of Health and Human Services or his/her designee and/or the carrier, MAC, FI or other contractor if designated by CMS 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 beneficiary's authorization and signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to the applicable provisions of the Social Security Act, Federal regulations, and CMS guidelines.
6. That it will ensure that all claims for Medicare primary payment have been developed for other insurance involvement and that Medicare 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 Medicare claim for a period of at least 6 years, 3 months after the bill is paid.

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9. That it will affix the CMS-assigned unique identifier (submitter identifier) of the Provider on each claim electronically transmitted to the carrier, MAC, FI or other contractor if designated by CMS.
  10. That the CMS-assigned unique identifier number (submitter identifier) or NPI 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 (including compliance with all provisions of the HIPAA security regulations) to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.
  12. That it will acknowledge that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this Agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law.
  13. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its carrier, MAC, FI or other contractor if designated by CMS, shall not be used by agents, officers, or employees of the billing service except as provided by the carrier, MAC, or FI (in accordance with §1106(a) of the Social Security Act {the Act}).
  14. That it will research and correct claim discrepancies.
  15. That it will notify the carrier, MAC, FI or other contractor if designated by CMS within two business days if any transmitted data are received in an unintelligible or garbled form.

**B. The Centers for Medicare and Medicaid Services (CMS) agrees to:**

1. Transmit to the Provider an acknowledgement of claim receipt.
2. Affix the carrier, MAC, FI or other contractor if designated by CMS number, as its electronic signature, on each remittance advice sent to the Provider.
3. Ensure that payments to Providers are timely in accordance with CMS' policies.
4. Ensure that no carrier, MAC, FI or other contractor if designated by CMS may require the Provider to purchase any or all electronic services from the carrier, MAC, or FI or from any subsidiary of the carrier, MAC, FI, or other contractor if designated by CMS or from any company for which the carrier, MAC, or FI has an interest. The carrier, MAC, FI or other contractor designated by CMS will make alternative means available to any electronic biller to obtain such services.
5. Ensure that all Medicare electronic billers have equal access to any services that CMS requires Medicare carrier, MAC, FI or other contractor is designated by CMS to make

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available to Providers or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the carrier, MAC, FI or other contractor is designated by CMS sells directly, indirectly, or by arrangement.

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

**NOTICE:**

Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document. 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 Medicare claims are submitted to carrier, MAC, FI or other contractor if designated by CMS. 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/Facility Name

\_\_\_\_\_  
Provider's Pay-to NPI Number

\_\_\_\_\_  
Group PTAN/Pay-to Provider Number

\_\_\_\_\_  
Provider's Physical Address

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

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

\_\_\_\_\_  
Daytime Telephone Number

- Check One:        New Submitter/Provider  
                      Joining an Existing Submitter ID#    Submitter ID to join \_\_\_\_\_

RETURN TO: EDI-4BCS  
PO Box 2181  
Little Rock, AR 72203-2181  
FedEx or UPS: 601 S. Gaines St. Little Rock, AR 72201  
Fax (501) 378-2265  
EDI Service Line (866) 582-3247  
[edi@arkbluecross.com](mailto:edi@arkbluecross.com)