



## Pennsylvania BCBS Realtime Cover Sheet

### For Initial Enrollment with this payer:

- If you have NOT submitted claims electronically to this payer, Payer Registration forms ARE required by the Payer. Please complete all fields on the following page as well as the attached Payer Registration forms and return to Emdeon for processing.
- All Payer Registration forms must contain original signatures in **BLUE INK**, no stamped signatures or photocopies are accepted.
- Registration with Emdeon takes 21 business days..
- Your Payer Registration form must include a valid Provider ID. Listing an invalid provider ID will delay the process.

### Instructions for submitting Realtime Forms:

- You must include this page when submitting Payer Registration forms to Emdeon
- Registration forms must be submitted to the address or fax number below  
To obtain forms or additional payer information, visit our website: <http://www.emdeon.com>

<b>This Registration form is for a:</b>			
<input type="checkbox"/> <b>Provider</b>		<input type="checkbox"/> <b>Group</b>	
<b>Name*</b>			
<b>Physical Address*</b>			
<b>City, State, Zip*</b>			
<b>Contact Name*</b>			
<b>Contact Phone</b>			
<b>Contact Email Address <sup>§</sup></b>			
<b>MID*</b>	<b>TID*</b>		
<input type="checkbox"/> <b>Provider ID*</b>		<input type="checkbox"/> <b>TAX ID*</b>	

\* Required Information

§ All Approval Notifications will be sent to this address

### Submit Original Payer Registration forms that require original signatures to:

Emdeon  
Attn: Payer Realtime  
3055 Lebanon Rd., Ste 2000  
Nashville, TN 37214

For all other forms:

Fax: (615) 231-4843

**To avoid rejections, please do not submit eligibility transactions before  
receiving Approval Notification from Emdeon.**

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**ANSI 4010A1 270 / 271 ELIGIBILITY INQUIRY  
ENROLLEE INFORMATION**

*The following pages should be completed to begin your enrollment for the electronic transmission of ANSI 4010A1 270/271 Eligibility Inquiry or to update your current EDI profile for Eligibility Inquiry. Questions should be directed to the EDI Service Line at 501-378-2419.*

Provider's Submitter Number Used (write "NEW" if new enrollee): \_\_\_\_\_

Provider's Name: \_\_\_\_\_

Provider's Pay-to Arkansas Blue Cross Provider Number: \_\_\_\_\_

Submitter's Address: \_\_\_\_\_

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

Contact Person: \_\_\_\_\_

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

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

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**TRANSMISSION INFORMATION**

➤ *Submitter plans to transmit 270 Eligibility Inquiry for providers in Arkansas.*

Arkansas Blue Cross Blue Shield – Arkansas Providers Only

Includes Blue Cross, Blue Shield, Health Advantage, and BlueAdvantage (USAbled) Administrators, Blue Card (ITS), Medipak, and Federal Employees Program (FEP).

➤ *Submitter will be using the following vendor to transmit 270 Eligibility Inquiry*

\_\_\_\_\_ Directly from facility to the EDI Services System

\_\_\_\_\_ Through a Clearinghouse – Submitter ID of Clearinghouse: \_\_\_\_\_

\_\_\_\_\_ Other Vendor: \_\_\_\_\_

Submitter ID of "Other Vendor": \_\_\_\_\_

An original signature is required from the Provider, CEO, CFO, COO or other duly authorized senior officer of Facility/Clinic/Clearinghouse/Billing Agent. Submitter agrees to send only transactions for Arkansas BlueCross BlueShield valid providers!

Provider's/Vendor Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**LETTER OF AUTHORIZATION - 270 / 271**

**Network Service Access of Arkansas Blue Cross & Blue Shield Systems  
TO BE SIGNED BY PROVIDER**

*Please complete the form below and return by mail to the address located at the bottom of this page. Faxed copies will not be accepted, as original signatures are required for our records. A Letter of Authorization should be returned for each provider listed in the "Provider Information" section of this enrollment.*

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

Vendor Name	
Vendor 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.*

*Please note that this Authorization Form applies to 270/271 transactions only. Submitting this form will not effect the provider's set-up for claim-submission, ERA's, or any other EDI transaction.*

By my signature below, I authorize the above named Vendor to access Arkansas Blue Cross & Blue Shield Systems on behalf of the above named Provider.

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

**EDI 4-South  
601 S. Gaines St.  
Little Rock, AR 72203**