

**ARKANSAS BLUE CROSS BLUE SHIELD
PAPER AND ELECTRONIC REGISTRATION REQUIREMENTS**

PAPER REGISTRATIONS

Agreements Required None required.

ELECTRONIC REGISTRATIONS

Agreements Required Provider must sign and return to United Concordia an original copy of the *Dental Electronic Data Interchange Enrollment Form*. Only participating Arkansas Blue Cross Blue Shield Providers may send electronic claims.

Return the completed form to:
Dental Electronic Services
PO Box 898215
Camp Hill, PA 17089-8215

Claims cannot be forwarded electronically until confirmation is received by CPS.

SPECIAL NOTES

**ECS Provider
Re-Registrations**

If currently submitting electronic claims through another clearinghouse, the provider must follow the above procedures for electronic registrations.



Dental Electronic Data Interchange Enrollment Form

NAME OF PROVIDER, SUPPLIER, OR GROUP

ADDRESS

STREET

CITY STATE ZIP CODE

CONTACT PERSON TELEPHONE NUMBER PROVIDER NO.

The following claim types may be submitted electronically:

- Arkansas Blue Cross and Blue Shield Dental Plans (except for FEP claims)
- Health Advantage Preventive Dental Rider

Please check one:

- New electronic biller using a Clearinghouse/Billing Service.
Name of Clearinghouse/Billing Service CLAIMS PROCESSING SERVICE STOP HERE. PLEASE PROCEED TO REVERSE SIDE.
- New electronic biller using Dental Claims Express (DCE). STOP HERE. PLEASE PROCEED TO REVERSE SIDE.
- New electronic biller using the software vendor listed below. PLEASE COMPLETE PARTS A, B, AND C.
- Existing electronic biller adding this new provider to source no. 94 _____ STOP HERE. PLEASE PROCEED TO REVERSE SIDE.

PART A: CHECK WITH VENDOR TO ENSURE SOFTWARE CAPABILITY:

Name of Software Vendor _____

Is your software capable of retrieving reports? YES NO

Do you wish to retrieve Submission Analysis Reports Electronically? YES NO

Do you wish to retrieve Reconciliation Electronically? YES NO

PART B: PLEASE CHECK ONE:

National Standard Format (NSF) specify version _____ OR American National Standard Institute (ANSI)
Element Separator _____
Segment Separator _____
Composite Separator _____

PART C: ELECTRONIC BILLING MEDIA DIAL-UP (TELEPHONE TRANSMISSION)

PLEASE SELECT YOUR MODEM TYPE:

Asynchronous:
Specify Modem Type: MNP Hayes/Z-Modem

Synchronous:

Electronic Data Interchange (EDI) Enrollment Form

The provider agrees to the following provisions for submitting Dental claims electronically to United Concordia Companies, Inc. (UCCI) on behalf of Arkansas Blue Cross and Blue Shield (ABCBS) policyholders:

A. THE PROVIDER AGREES:

1. That it will be responsible for all Dental claims submitted to UCCI by itself, its employees, or its agents.
2. That it will not disclose any information concerning a Dental subscriber/ sponsor or to any other person or organization except UCCI or ABCBS without the express written permission of the Dental subscriber/ sponsor or his/her parent or legal guardian, or where required, the care and treatment of a subscriber/ sponsor who is unable to provide written consent, or to bill insurance primary or supplementary to Dental, or as required by State or Federal law.
3. That it will submit claims only on behalf of those Dental beneficiaries who have given their written authorization to do so, and to certify that required subscriber/ sponsor 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:
 - Subscriber/ sponsor's name,
 - Subscriber/ sponsor's Dental Insurance claim number
 - Procedure/service performed
5. UCCI and ABCBS have 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 subscriber/ sponsor's authorization and signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to UCCI and ABCBS guidelines.
6. That it will ensure that all claims for primary payment by ABCBS have been developed for other insurance involvement and that ABCBS 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 Dental claim for a period of at least 6 years, 3 months after the bill is paid.
9. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all subscriber/ sponsor specific data from improper access.
10. That it will acknowledge that all claims will be paid from ABCBS funds, that the submission of such claims is a claim for payment under one of the ABCBS programs, 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, State and Local law.
11. That it will establish and maintain procedures and controls so that information concerning Dental beneficiaries, or any information obtained from UCCI or ABCBS shall not be used by agents, officers, or employees of the billing services except as provided by the contractor (in accordance with §1106 (a) of the Act).
12. That it will research and correct claim discrepancies.
13. That it will notify UCCI within 2 business days if any transmitted data are received in an unintelligible or garbled form.
14. That by enrolling to submit Dental claims electronically to UCCI, it remains responsible for those claims. In accepting claims submitted electronically to UCCI from any billing service or through the use of a particular product which accomplishes this process, UCCI is not attesting to the appropriateness of the methods used by the billing service or to the accuracy of a particular vendor's product which purportedly facilitates such electronic submissions. The provider furnishing the item or service for whom payment is claimed under UCCI retains the

responsibility for any claim regardless of the format in which it chooses to submit the claim.

B. UNITED CONCORDIA COMPANIES, INC., WORKING ON BEHALF OF ARKANSAS BLUE CROSS AND BLUE SHIELD, WILL:

1. Transmit to the provider an acknowledgment of claim receipt.
2. Affix the intermediary/carrier number, as its electronic signature on each remittance advice sent to the provider.
3. Ensure that payments to providers are timely in accordance with policies established for ABCBS policyholders.
4. Ensure that no contractor may require the provider to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest. The contractor will make alternative means available to any electronic biller to obtain such services.
5. Ensure that all Dental electronic billers have equal access to any services that UCCI makes 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 UCCI sells directly, indirectly, or by arrangement.
6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE: Federal, State or Local law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by UCCI on behalf of ABCBS policyholders.

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 Dental claims are submitted to UCCI on behalf of ABCBS policyholders. Either ABCBS or the provider 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 (please print or type)		
TITLE		
ADDRESS		
CITY	STATE	ZIP CODE
SIGNATURE		
DATE		



CERTIFICATE OF RESPONSIBILITY

EMC II

(To be Executed Between the Physician or Supplier and Billing Service)

It is recognized by CLAIMS PROCESSING SERVICE, INC. (hereinafter referred to as the Billing Service)

as the Billing Agent or Billing Service), that certain advantages will accrue to it and the undersigned physician or supplier through an arrangement whereby the Billing Agent can submit claims on behalf of the undersigned physician or

supplier by electronic medium to BLUE CROSS AND BLUE SHIELD OF ALABAMA Carrier

(hereinafter referred to as the Carrier), rather than by written requests for payment. This agreement between me and the Billing Agent is to be used for purpose of allowing the Carrier to process claims submitted on my behalf by the Billing Agent. Therefore, the undersigned physician or supplier agrees to the following:

1. I hereby authorize the Billing Agent to submit claims on my behalf, and I hereby warrant that the services have been rendered by me.
2. I agree that the Secretary of HHS, his designee or agent, or the Carrier has the right to audit and confirm any information submitted by me, and has access to my claim documentation records and all records, including medical records, in my office or any other place for that purpose. Any incorrect payments which are discovered as a result of such an audit will be adjusted according to the applicable provisions of the Social Security Act as amended, Federal Regulations, or Medicare guidelines.
3. I shall not knowingly submit claims which conflict with the Social Security Act as amended, Federal Regulations, or Medicare guidelines.
4. I agree that all original source documents will be maintained. I will ensure that every electronic entry can be associated and identified with a source document. All original source documents will be retained for a period of seventy-two (72) months following the month of payment by the Carrier. Medical records will be retained pursuant to the applicable State law.
5. In submitting machine readable claims, I understand that I am certifying that required patient signatures or appropriate signatures on behalf of patients are on file in accordance with prescribed procedures and that anyone who misrepresents or falsifies essential Medicare claims information may, upon conviction, be subject to fine and imprisonment under Federal law. If assignment is accepted, I agree that the reasonable charge, as determined by the carrier, shall be the full charge for the services on the claims.
6. The Carrier has the right not to accept claims covered by this agreement for any reason.

- 7. I understand that I am responsible for any Medicare claim submitted on my behalf by the Billing Agent and that I am liable for any subsequent adjustment of that payment.
- 8. I UNDERSTAND THAT THE SUBMISSION OF AN ELECTRONIC MEDIUM CLAIM IS A CLAIM FOR MEDICARE PAYMENT AND THAT ANYONE WHO MISREPRESENTS OR FALSIFIES ANY RECORD OR OTHER INFORMATION ESSENTIAL TO THAT CLAIM OR THAT IS REQUIRED PURSUANT TO THIS AGREEMENT -Y UPON CONVICTION, BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL LAW.

I have read and agree to the above by signing below on this _____ day of _____, in the year _____.

Physician -- Supplier Name (Print)

Address

Signature

Provider Number

Claims Processing Service, Inc.
Billing Service Name

220 Burnham St.
So. Windsor, CT 06074
Address

Dennis Jean
Signature