



220 Burnham Street • South Windsor, CT 06074  
 Vox 888-255-7293 • Fax 860-289-0055

**ALABAMA BLUE CROSS BLUE SHIELD  
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

<b>PAYER ID NUMBER</b>	<b>CBAL1</b>
<b>ELECTRONIC REGISTRATIONS</b>  Agreements Required	<p><b>Emdeon Business Services Provider Enrollment Form</b></p> <ul style="list-style-type: none"> <li>• Please complete all requested information</li> </ul> <p><b>EDI Enrollment Request for New Submitter ID</b></p> <ul style="list-style-type: none"> <li>• Pg 1 Section 1: Please complete all requested information.</li> <li>• Pg 1 Section 4: Please complete all requested information. Provider or authorized representative must sign and date.</li> <li>• Pg 2: Please complete all requested information.</li> </ul>
<b>SPECIAL NOTES</b>	<p>All Providers are required to register their NPI numbers with AL BCBS in order to send electronic claims. Providers should email their NPI numbers to:  <a href="mailto:npi-helpbox@bcbs.org">npi-helpbox@bcbs.org</a>      or call      EDI department at 205-220-6899 option 2</p>
<b>SEND REGISTRATION FORMS TO</b>	<p align="center">Emdeon Business Services      220 Burnham Street      South Windsor, CT 06074      Attn: Provider Enrollment      Or      Fax to: 860-289-0055</p>
<b>ENROLLMENT CONFIRMATION</b>	<ul style="list-style-type: none"> <li>▪ Enrollment will be coordinated between Emdeon Business Services and Blue Cross Blue Shield.</li> <li>▪ The enrollment process takes approximately 10-15 business days.</li> </ul>
<b>CHANGING ELECTRONIC BILLING AGENTS</b>	<p>If the Provider currently submits claims through another Billing Agent other than Emdeon Business Services each Provider must re-enroll following the procedures listed above.</p>
<b>CONTACT PHONE NUMBERS</b>	<p>BCBS In-state Alabama Providers 205-985-5378      BCBS Out-of-State Providers (888) 783-5113      Emdeon Business Services (888) 255-7293</p>



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**PROVIDER ENROLLMENT FORM**

Print/Type the following:

Insurance Carrier: **Alabama Blue Cross Blue Shield payer ID CBAL1**

Provider/Organization Name: \_\_\_\_\_

Tax Identification or Social Security Number: \_\_\_\_\_  
*(Number that will be used to submit electronic claims)*

Software Vendor: \_\_\_\_\_

Group NPI Number: \_\_\_\_\_  
*(if applicable)*

Name	Rendering	NPI
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Address: \_\_\_\_\_

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

Office Contact Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

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



An Independent Licensee of the Blue Cross and Blue Shield Association.

Section I.

PRACTICE/FACILITY NAME: ADDRESS: CITY: STATE: ZIP:

Section II.

VENDOR/CLEARINGHOUSE NAME: ENVOY / CPS dba EMDEON DENTAL CONTACT NAME: STACEY WIDUN BLUE CROSS VENDOR ID: 091

Section III.

Required Information: Indicate the requested transaction(s): 837 - claim (batch) 270/276/278 - eligibility, claim status, and referral (real-time) Indicate submitter ID: CPS CPS00001 Optional Information: Indicate the FTP directory where audit reports should be delivered if different than submitter ID: CPS00001 Check here if a dial-up connection is needed. NOTE: A dial-up connection is not required if the FTP server is accessed through the internet or a frame relay connection.

Section IV. (Continue provider list onto page 2 if additional space is needed.)

Table with 3 columns: NAME OF PROVIDER, PROVIDER NPI, TAX ID

Blue Cross will assign provider passwords and forward to the vendor.

The undersigned hereby:

- Represents and warrants that he or she has full power and authority to execute this agreement on behalf of the health care provider identified in Section I (Provider) and to bind the Provider to the terms and conditions of this agreement;
Authorizes Blue Cross and Blue Shield of Alabama (BCBSAL) (1) to disclose protected health information to the business associate identified in Section II (Business Associate); and (2) to return Provider passwords to Business Associate;
Agrees to notify BCBSAL if the Business Associate changes;
Agrees that Provider will be responsible for all electronic transactions submitted to BCBSAL by Provider, its employees, and its agents;
Agrees that BCBSAL has the right to audit and confirm information submitted by or on behalf of Provider and shall have access to all original source documents and medical records related to Provider's submissions. All incorrect payments shall be adjusted in accordance with BCBSAL guidelines;
Agrees that Provider will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all data from improper access; and
Agrees to establish and maintain procedures and controls so that information concerning Blue Cross subscribers, or any information obtained from Blue Cross, shall not be used by agents, officers, or employees of the billing service except as provided by Blue Cross.

Authorized Representative of Provider

Date

