



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

**KANSAS CITY BLUE CROSS OF MISSOURI  
 DENTAL CLAIMS ENROLLMENT REGISTRATION**

<b>PAYER ID NUMBER</b>	<b>PRINT CLAIMS ONLY</b>
<b>REGISTRATIONS</b>	<p><b>Emdeon Business Services Provider Enrollment Form</b>          Please fill in the following:</p> <ul style="list-style-type: none"> <li>• Provider name</li> <li>• Tax ID or Social Security Number</li> <li>• Group Number (if applicable)</li> <li>• Rendering Name and Numbers (required if part of group)</li> <li>• Address</li> <li>• City, State, Zip Code</li> <li>• Office Contact Name</li> <li>• Telephone Number</li> <li>• Facsimile Number</li> <li>• Date mailed to CPS</li> </ul>
<b>SPECIAL NOTES</b>	<ul style="list-style-type: none"> <li>▪ If you do <b>NOT</b> have a Kansas City Blue Cross of Missouri Provider Number, you <b>MUST</b> submit a paper claim first. After the paper claim is received, the Provider will be mailed a Remittance Advice with the Provider Number on it.</li> <li>▪ After you have received your Provider Number, you may then fill out the attached paperwork. Do <b>NOT</b> submit paperwork without a valid Provider Number, otherwise you will delay the process and are at risk for rejected claims.</li> <li>▪ The Provider Number assigned will be 8 digits.</li> </ul>
<b>SEND REGISTRATION FORMS TO:</b>	<p>Please mail or fax completed forms to:</p> <p style="text-align: center;">Emdeon Business Services          Attn: Provider Registration          220 Burnham Street          South Windsor, CT 06074          Or          Fax # 860-289-0055</p>



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<b>REGISTRATION CONFIRMATION</b>	Emdeon Business Services will notify the Provider's Software Vendor when he/she is approved to submit claims.
<b>CONTACT PHONE NUMBERS</b>	Provider Services (800) 432-3587 IN-STATE Provider Services (800) 432-0216 OUT OF STATE Emdeon Business Services (888) 255-7293



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**PROVIDER ENROLLMENT FORM**

Print/Type the following:

Insurance Carrier: **Kansas City Blue Cross of Missouri – print claims only**

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

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

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

Group Number: (8 digits) \_\_\_\_\_  
*(if applicable)*

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

Name	Rendering Number: (8 digits)	NPI
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

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

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

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

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