



emdeon™

business services

220 Burnham Street • South Windsor, CT 06074

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

<b>PAYER ID NUMBER</b>	<b>23739</b>
<b>ELECTRONIC REGISTRATIONS</b>  Agreements Required	<b>Emdeon Business Services Provider Enrollment Form</b> <ul style="list-style-type: none"> <li>• Please complete all requested information.</li> </ul>
<b>SPECIAL NOTES</b>	<ul style="list-style-type: none"> <li>▪ If a provider does not have a 10 byte (digit) alpha numeric Louisiana Blue Cross Blue Shield provider ID the provider must contact Louisiana Blue Cross Blue Shield to obtain one. <b><i>Only in state providers may apply for a provider number.</i></b></li> </ul>
<b>SEND REGISTRATION FORMS TO:</b>	<p>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>▪ Once Emdeon Business Services has received the <b><i>Provider Enrollment Form</i></b>, Louisiana Blue Cross Blue Shield will be contacted with a request for enrollment.</li> <li>▪ Once approval is received from Louisiana Blue Cross Blue Shield, the Provider will be contacted that they may begin sending electronic claims.</li> </ul>
<b>CHANGING ELECTRONIC BILLING AGENTS</b>	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.
<b>CONTACT PHONE NUMBERS</b>	<p>Emdeon Business Services                    888-255-7293 Louisiana Blue Cross Blue Shield        225-291-4334</p>



**PROVIDER ENROLLMENT FORM**

Print/Type the following:

Insurance Carrier: **Louisiana Blue Cross Blue Shield – payer ID 23739**

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: \_\_\_\_\_  
*(if applicable)*

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

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

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

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

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

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

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