



emdeon™

business services

220 Burnham Street • South Windsor CT 06074

Vox 888-255-7293 • Fax 860-289-0055

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

| | | | | | | | |
|--|---|--------------------------|--------------|-----------------------------|--------------|--------------------|--------------|
| PAYER ID NUMBER | CBNE1 | | | | | | |
| ELECTRONIC REGISTRATIONS Agreements Required | Emdeon Business Services Provider Enrollment Form Required for both in and out of state providers. <ul style="list-style-type: none"> • Please complete all information. | | | | | | |
| SPECIAL NOTES | Nebraska BCBS requires all providers to have a provider number assigned before they will accept claims electronically. If you need a provider number assigned you may call Nebraska BCBS Provider Relations at 800-821-4787. | | | | | | |
| SEND REGISTRATION FORMS TO: | Emdeon Business Services 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment Or Fax to: (860) 289-0055 | | | | | | |
| ENROLLMENT CONFIRMATION | <ul style="list-style-type: none"> ▪ Enrollment will be coordinated between Emdeon Business Services and Nebraska BCBS. ▪ Emdeon Business Services will notify either the provider or their software vendor when approval is received from Nebraska BCBS. | | | | | | |
| CHANGING ELECTRONIC BILLING AGENTS | 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. | | | | | | |
| CONTACT PHONE NUMBERS | <table> <tr> <td>Emdeon Business Services</td> <td>888-255-7293</td> </tr> <tr> <td>Nebraska Provider Relations</td> <td>800-821-4787</td> </tr> <tr> <td>Nebraska Help Desk</td> <td>402-398-3603</td> </tr> </table> | Emdeon Business Services | 888-255-7293 | Nebraska Provider Relations | 800-821-4787 | Nebraska Help Desk | 402-398-3603 |
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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Nebraska BCBS – payer ID CBNE1**

Provider/Organization Name: _____

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

Software Vendor: _____

Group Number: _____
(if applicable)

Group NPI: _____
(if applicable)

| Name | Number | Rendering | NPI |
|-------|--------|-----------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____