



emdeon™

Emdeon **Realtime** Provider Information Form

This form is to ensure accuracy in updating the appropriate account

1	Provider Organization			Customer #			
Practice/ Facility Name				Tax ID			
Provider Name							
Address				City/State			Zip Code
Contact Name							
E-mail Address				Telephone			Fax
MID				TID			TPG

2	Payer						
Payer Name/ID							
Group Provider ID	Individual Provider ID			Billing NPI			

3	Confirmations						
Send Emdeon Confirmations To:							
Special Instructions:	<ul style="list-style-type: none"> All Payer Registration forms must contain signatures when applicable, stamped signatures or photocopies are accepted. SUBMIT COMPLETED FORM TO: <p style="text-align: center;"> Email: RTenrollment@emdeon.com Fax: 615.885.3713 </p>						

EMDEON REVISION FORM DATE:

ELECTRONIC SOLUTIONS - ELECTRONIC CONNECTIVITY REQUEST

Please complete the following form and fax the form to **Electronic Solutions, (919) 765-7101**
A Connectivity Request form is required for each provider group.

PROVIDER NAME		NATIONAL PROVIDER ID	BCBSNC PROVIDER NUMBER
CONTACT NAME		TITLE	
MAIL ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS (REQUIRED)	

VENDOR/CLEARINGHOUSE NAME Emdeon Business Services	CONTACT NAME Real-Time Enrollment	TITLE Provider Services
MAIL ADDRESS 1283 Murfreesboro Road	CITY Nashville	STATE TN
		ZIP CODE 37217
PHONE NUMBER (615) 565-2500	FAX NUMBER (615) 234-0834	EMAIL ADDRESS (REQUIRED) rtenrollment@emdeon.com

BILLING SERVICE NAME	CONTACT NAME	TITLE
MAIL ADDRESS	CITY	STATE
		ZIP CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS (REQUIRED)

Electronic Transactions	Connectivity Mode					Effective Date
	Batch				Real Time	
	HTTPS	FTP (Windows GUI)	FTP (Command Line)	SOAP	SOAP	
Eligibility Inquiry – 270/271					X	
Claims Inquiry – 276/277						
Auth. & Referral – 278						
Electronic Remit – 835 (Par providers only)						
Institutional Claims – 837I						
Professional Claims – 837P						

Mail Box Password (8 characters): _____

Type of Sender: Provider Clearinghouse Billing Service CAQH/CORE certified: Yes No

Sender/Receiver ID (Federal Tax ID): 200497265

Transaction Flow: From provider site directly to BCBSNC
 From provider site to billing service to BCBSNC
 From provider site to clearinghouse to BCBSNC
 From provider site to billing service to clearinghouse to BCBSNC
 Other – Specify: _____

Date _____ Print Name/Title (Required) _____ Authorized Signature (Required) _____

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