



emdeon®

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**

PAYER ID NUMBER	CBAL1
ELECTRONIC REGISTRATIONS Agreements Required	Emdeon Provider Enrollment Form <ul style="list-style-type: none">• Please complete all requested information EDI Enrollment Request for Existing Submitter ID <ul style="list-style-type: none">• Pg 1 Section 1: Please complete all requested information.• Pg 1 Section 4: Please complete all requested information. Provider or authorized representative must sign and date.• Pg 2: Please complete all requested information.
SPECIAL NOTES	To register NPI numbers contact AL BCBS Provider Enrollment. <ul style="list-style-type: none">• Access enrollment forms online https://www.bcbsal.org/providers/forms.cfm• Email credentialing@bcbsal.org• Call the Automated VRU: 205-220-6765.• Fax (provider credentialing applications and related documents): 205-220-9545.
SEND REGISTRATION FORMS TO	Emdeon 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment Or Fax to: 860-289-0055
ENROLLMENT CONFIRMATION	Emdeon will notify the provider or their PMS vendor, as defined by the PMS vendor, when registration is complete.
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently submits claims through another Billing Agent other than Emdeon each Provider must re-enroll following the procedures listed above.



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CONTACT PHONE NUMBERS	BCBS In-state Alabama Providers BCBS Out-of-State Providers Emdeon Provider Enrollment	205-985-5378 888-783-5113 888-255-7293
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PROVIDER ENROLLMENT FORM

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

Print/Type the following:

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: _____



Existing Submitter ID:

CPS00001

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.

Indicate the requested transaction(s): 837 – claim (batch)
 270/276/278 –eligibility, claim status, and referral (real-time)

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

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

