

**RHODE ISLAND BLUE CROSS/BLUE SHIELD
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

PAYER ID NUMBER	CB870
ELECTRONIC REGISTRATIONS Agreements Required	<p>Emdeon Business Services Provider Enrollment Form</p> <ul style="list-style-type: none"> • Please complete all requested information. <p>Rhode Island BCBS Dental Provider Enrollment Form</p> <ul style="list-style-type: none"> • Please complete all requested information. • Provider Signature and Provider ID are required.
SPECIAL NOTES	If you participate in either the Blue Cross & Blue Shield of Massachusetts or DenteMax networks, please call Blue Cross Dental Professional Relations to obtain the correct Provider number for filing claims at 1-800-831-2400, Mon-Fri 8:15- 4:30 EST.
SEND REGISTRATION FORMS TO:	<p>Please return completed form to:</p> <p align="center">Emdeon Business Services 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment Or Fax to: 860-289-0055</p>
ENROLLMENT CONFIRMATION	<ul style="list-style-type: none"> • Enrollment will be coordinated between Emdeon Business Services and Blue Cross Blue Shield. Emdeon will notify the provider or their software vendor when approval is received.
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	<p>Rhode Island BCBS Professional Relations 800-831-2400 Emdeon Business Services 888-255-7293</p>



PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Rhode Island Blue Cross Blue Shield – payer ID CB870**

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: _____

Blue Cross Blue Shield of Rhode Island

444 Westminster St
Providence, RI 02903

DENTAL PROVIDER ENROLLMENT FORM

Print/Type the following:

Provider/Organization Name: _____

Provider Number that will be used to submit electronic claims: _____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Software Vendor: _____

Provider Signature: _____



Date: _____