

**Blue Cross and Blue Shield of North Carolina
Individual Provider Enrollment Application**
(Please print or type)

<i>(Internal Use Only)</i>	BCBS#: _____
Analyst: _____	Eff Date: _____ Date rec: _____
Comp date: _____	Date board called: _____

Name: _____ Degree: _____ Specialty: _____
Last First Mid Init

National Provider Identifier (NPI): _____ Taxonomy Code/Description: _____

Soc. Sec. No.: _____ Phone number: _____

DEA Number: _____ License number:*** _____ Date originally issued: _____
Month/Day/Year

*****Please attach a copy of your original license and your most recent license renewal slip**

UPIN number: _____ Medicare provider no.: _____

Actual office location: _____
Street/Suite no./Apt. no., etc.

_____ City State Zip County

Billing Address (if different from above): _____
Street/Suite No./Apt. No., etc.

_____ City State Zip

If individual practice, specify date practice established: _____

(internal use only)

Notes:

Have you ever had a BCBSNC provider number before? Yes _____ No _____

If you checked "Yes", then list number(s): _____

Are you a member of a group, clinic or partnership? Yes _____ No _____

If you checked "Yes", then specify the following:

_____ BCBSNC group provider number (if applicable) _____ Group tax identification number (IRS #) _____ Date you joined group, clinic, etc.

Indicate place(s) service(s) will be rendered:

- _____ inpatient hospital
- _____ outpatient hospital
- _____ office
- _____ home or skilled nursing facility
- _____ all of the above
- _____ other specify: _____

In order to insure compliance with Internal Revenue Service regulations, we must have your tax identification information to process your application. Please complete the enclosed W9 form and include it with your completed application. The W9 must indicate the name of the individual, group, corporate entity or partnership that is on record with the Internal Revenue Service.

Assignment of a Blue Cross and Blue Shield of North Carolina provider number does not indicate participation with any product. If you are interested in participation with a product you must contact your Professional Relations field office.

FIELD OFFICE USE ONLY

Date Mailed: _____ Initials: _____