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

(Internal use only) BCBS#:_____
Analyst:_____ Eff. Date:_____ Date rec:_____
Comp date: Date board called:_____

Group Name:_____ Specialty:_____

Tax Id (IRS #).:_____ Medicare number:_____ Phone number:_____

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

Actual office location:_____Date group established_____
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

(Internal use only)

Notes:

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

1. _____inpatient hospital 2. _____outpatient hospital
3. _____office 4. _____home or skilled nursing facility
5. _____all of the above 6. _____other specify:_____

Has group ever had a BCBSNC provider number before? Yes____No_____

If checked "Yes", then list number:_____

Does group currently file electronically with Blue Cross Blue Shield of North Carolina? Yes ____No _____

Please complete for each individual provider in the group(attach additional pages as necessary)**:**

Name	BCBSNC prov #	License number	Year licensed	Specialty	NPI

In order to insure compliance with IRS 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 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 Network Management field office.

FIELD OFFICE USE ONLY. Date Mailed: _____Initials:_____