Blue Cross and Blue Shield of North Carolina Individual Enrollment Application **Please print in blue or black ink or type.**	**Please Check One:** Non Participating Enrollment Request ☐ Participating Contract Request ☐

Name: _____ Degree: _____ Specialty: _____
Last First Middle

Social Security Number: _____ Specialist ☐ Primary Care ☐

Hospitalist ☐ Other ☐

National Provider Identifier (NPI): _____ _____
Type I Type II (Billing NPI)

License#: _____ Taxonomy Code/Description: _____ Medicare Provider#: _____
(Please attach most recent copy) **(Required for Blue Medicare)**

CLIA# (if applicable): _____
(Please attach most recent copy)

Office Location Information: (Service location) **Please list additional service locations on Page 2**

Physical Address: _____
Street **Suite, Apt, Unit, Floor, etc**

_____
City **State** **Zip** **County**

Phone: _____ _____
Appointment/Patient Phone Number **Fax Number**

Post Service – Medical Record Requests: _____
Fax Number or Mailing Address

Practice Email Address: _____

Billing Address (if different from physical address):

_____ _____
Street/PO Box **Suite, Apt, Unit, Floor, etc**

_____
City **State** **Zip**

Have you ever had a BCBSNC provider number (PPN)? Yes ☐ No ☐ If yes, please list the number(s) _____

Is this application intended to affiliate you with an existing practice? Yes ☐ No ☐ If yes, please specify the established group's information below:

Group's Type II/Billing NPI	Group's BCBSNC PPN	Group's Tax ID#	Date you joined the group

Indicate the place(s) of service where services will be rendered:

1. ☐ Inpatient Hospital
2. ☐ Outpatient Hospital
3. ☐ Office
4. ☐ Home Health/Skilled Nursing Facility
5. ☐ All of the above
6. ☐ Other Specify: _____

Does your location have high-tech imaging equipment (PET, MRI, CT, Nuclear Medicine or Echocardiography? Yes ☐ No ☐

In order to ensure compliance with the Internal Revenue Service (IRS) regulations, we must have you tax identification information to process your application. **When submitting this enrollment application, please be sure to include a completed W9** containing the billing entity information. Visit our external provider portal ***WWW.BCBSNC.COM*** for a copy of the W9 and other instructions for this application.

Please Note: Enrollment does not establish you or your practice as an in-network BCBSNC provider. Separate processes are required for credentialing and contracting. Please see the Enrollment Instructions document on the provider portal mentioned

above.

For additional information, please contact our Network Management Provider Services line at 1-800-777-1643 and select option 6.

Signature of Authorized Practice Representative:_____

Date: _____ Contact Phone # _____

Additional Office Locations

Please note: Only locations where the practitioner works **2 or more days a week** will display in our directory. Please indicate for each location listed below.

Office location:

Street Address Suite, Apt, etc.

City State ZIP County

Appointment Phone # Location Billing NPI

Will the practitioner work 2 or more days a week at this location? ☐ Yes ☐ No

Office location:

Street Address Suite, Apt, etc.

City State ZIP County

Appointment Phone # Location Billing NPI

Will the practitioner work 2 or more days a week at this location? ☐ Yes ☐ No

Office location:

Street Address Suite, Apt, etc.

City State ZIP County

Appointment Phone # Location Billing NPI

Will the practitioner work 2 or more days a week at this location? ☐ Yes ☐ No

Office location:

Street Address Suite, Apt, etc.

City State ZIP County

Appointment Phone # Location Billing NPI

Will the practitioner work 2 or more days a week at this location? ☐ Yes ☐ No

Office location:

Street Address Suite, Apt, etc.

City State ZIP County

Appointment Phone # Location Billing NPI

Will the practitioner work 2 or more days a week at this location? ☐ Yes ☐ No