

**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

Taxonomy Code: \_\_\_\_\_

Specialist  Primary Care

Hospitalist  Other

National Provider Identifier (NPI): \_\_\_\_\_  
Type I Type II (Billing NPI)

License#: \_\_\_\_\_ 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](http://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:

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Street Address Suite, Apt, etc.

---

City State ZIP County

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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