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

Group Name: _____ Specialty: _____

Tax Id (IRS#): _____ National Provider Identifier (NPI): _____
(Attach W9) Type II (Billing NPI)

Taxonomy Code/Description: _____ Medicare Provider#: _____
(Required for Blue Medicare)

CLIA# (if applicable): _____
(REQUIRED: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**

Practice Email Address: _____

Billing Address _____

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

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

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 ☐

List individual providers below:

Provider Name	BCBSNC Provider # (PPN)**	License Number	Year of Licensure	Specialty	National Provider Identifier NPI

****Individual Enrollment Applications are required for each provider to obtain an individual BCBSNC PPN.**

*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**