400 Vermillion Street ● Hastings, MN 55033
Ph 800-482-3518 ● Fax 651-389-9152
www.edsedi.com

RHODE ISLAND BLUE CROSS/BLUE SHIELD
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

PAYER ID NUMBER	CB870
ELECTRONIC REGISTRATIONS Agreements Required	**EDS Provider Enrollment Form** • Please complete all requested information. • Rhode Island BCBS Dental Provider Enrollment Form **Please complete all requested information.** • Provider Signature and Provider ID are required. • Please list the Tax ID and billing NPI as the Provider ID on the RI BCBS form.☐
SPECIAL NOTES	If you participate in either the Blue Cross & Blue Shield of Massachusetts or DenteMax networks, please call Blue Cross Dental Professional Relations to obtain the correct Provider number for filing claims at 1-800-831-2400, Mon-Fri 8:15- 4:30 EST.
SEND ENROLLMENT FORMS TO:	Electronic Dental Services 400 Vermillion Street, Suite 8 Attn: Enrollment Hastings, MN 55033 E-mail: Enrollment@edsedi.com or Fax: 651-389-9152
ENROLLMENT CONFIRMATION	Enrollment will be coordinated between EDS and Blue Cross Blue Shield. EDS will notify the provider or their software vendor when approval is received.
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently receives claims through another Billing Agent other than Electronic Dental Services each Provider must re-enroll following the procedures listed above.
CONTACT PHONE NUMBERS	Rhode Island BCBS Professional Relations 800-831-2400 Electronic Dental Services 800-482-3518

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PROVIDER ENROLLMENT FORM

Print/Type the following:
Insurance Carrier: **Rhode Island Blue Cross Blue Shield – payer ID CB870**

Provider/Organization Name: _____

Tax Identification or Social Security Number: _____
(Number that will be used to submit electronic claims)

Software Vendor: _____

Group NPI: _____
(if applicable)

Rendering Name	NPI
_____	_____
_____	_____
_____	_____
_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____

Blue Cross Blue Shield of Rhode Island

444 Westminster St
Providence, RI 02903

DENTAL PROVIDER ENROLLMENT FORM

Print/Type the following:

Provider/Organization Name: _____

Provider Number that will be used to submit electronic claims: _____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Software Vendor: _____

Provider Signature: _____

Date: _____