400 Vermillion Street, Hastings, MN 55033
Ph: 800-482-3518 ● Fax: 651-389-9152

BLUE CROSS BLUE SHIELD OF MISSISSIPPI
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

PAYER ID NUMBER	**CBMS1**
ELECTRONIC REGISTRATIONS **Agreements Required**	**Electronic Dental Services Provider Enrollment Form** • **Please complete all requested information** **BCBS of Mississippi Electronic Claims Information Worksheet** • **Please complete all requested information.**
SEND REGISTRATION FORMS TO	Electronic Dental Services 400 Vermillion St Hastings, MN 55033 Attn: Provider Enrollment Or Fax to: 651-389-9152
ENROLLMENT CONFIRMATION	**Enrollment will be coordinated between Electronic Dental Services and Blue Cross Blue Shield of Mississippi. EDS will notify the provider or their software vendor when enrollment is complete.**
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently submits claims through another Billing Agent other than Electronic Dental Services each Provider must re-enroll following the procedures listed above.
CONTACT PHONE NUMBERS	**Electronic Dental Services Provider Enrollment 800-482-3518** **BCBS of Mississippi EDI Services 800-222-8046**

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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Mississippi BCBS – payer ID CBMS1**

Provider/Organization Name: ____

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

Software Vendor: ___EDS____

Group Number: ___________________________
(if applicable)

Group NPI Number: ______________________
(if applicable)

Name	Rendering Number	NPI
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Address: ____

City, State, Zip Code: ____

Office Contact Name: __Terri____

Telephone Number: __651-480-8090________________ Fax Number: ________________

Date: ______________________________

BlueCross BlueShield of Mississippi

DENTAL ELECTRONIC CLAIMS INFORMATION
Worksheet

CLEARINGHOUSE NAME: Change Healthcare f.k.a. Emdeon	
PROVIDER INFORMATION (PLEASE PRINT)	
Provider Name	
Facility /Practice Name	
Address	
City, State, ZIP	
Contact Name	
Email Address	
Telephone	Fax

IDENTIFICATION NUMBERS	
TAX ID	Provider ID
Provider ID	Provider ID
Provider ID	Provider ID
Provider ID	Provider ID
Provider ID	Provider ID
Provider ID	Provider ID