Blue Cross Blue Shield of North Carolina

Attention Providers:

In order to start receiving your ERAs Blue Cross Blue Shield of North Carolina Dental through EDS, you will need to print and review the enrollment form. Please sign the form and submit to EDS with required documentation noted below.

Payer:	Blue Cross Blue Shield of North Carolina
Payer ID:	61473
For Enrollment Questions:	Contact the EDS Enrollment Department at (800) 482 -3518 or Enrollment@edsedi.com
Payer Enrollment Application:	**ECHO ANSI 835 Enrollment Form**
Upload, Email or Fax Application to:	Enrollment@edsedi.com Fax (800) 389-9152
Approval Process and Timeframes:	Payer estimates 3 week for processing. EDS will deliver ERAs directly to the EDS Portal upon receipt.

EFT/ERA DEG 3 – Provider Contact Information

Provider Contact Name: ______________________________
(Name of contact in provider office for handling EFT issues)

Provider Contact, Title *(optional):* ______________________________

Telephone Number: ____________________ **Telephone Extension** *(optional):* ____________________
(Associated with contact person)

E-mail Address: ______________________________
(An electronic mail address at which the health plan might contact the provider)

EFT/ERA DEG 4 – Provider Agent Information

Provider Agent Name: ______________________________
(Name of provider's authorized agent)

Provider Agent Contact Name: ______________________________
(Name of contact in agent office for handling EFT issues)

Provider Agent Contact, Title *(optional):* ______________________________

Telephone Number: ____________________ **Telephone Extension** *(optional):* ____________________
(Associated with Provider Agent contact person)

E-mail Address: ______________________________
(An electronic mail address at which the health plan might contact the provider)

EFT DEG 7 – Financial Institution Information

Financial Institution Name: ______________________________
(Official name of the Provider's financial institution)

Telephone Number: ____________________ **Telephone Extension (optional):** ____________________
(A contact phone number at the Provider's bank)

Financial Institution Routing Number: ______________________________
(A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited)

Type of Account at Financial Institution: ______________________________
(The type of account the provider will use to receive EFT payment, e.g., Checking, Saving)

Provider's Account Number with Financial Institution: ______________________________
(Provider's account number at the financial institution to which EFT payments are to be deposited)

Account Number Linkage to Provider Identifier. Select one option below.
(Provider preference for grouping [bulking] claim payments – must match preference for v5010 X12 835 advice)

Provider Tax Identification Number (TIN) **National Provider Identifier (NPI)**

ERA DEG 7 – Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)
(Provider preference for grouping [bulking] claim payment remittance advice – must match preference for EFT payment)

Provider Tax Identification Number (TIN): ______________________________
(Required if NPI is not applicable)

National Provider Identifier (NPI): ______________________________
(Required if TIN is not applicable)

Method of Retrieval: ______________________________
(The method in which the provider will receive the ERA from the health plan [e.g., download from health plan website, clearinghouse, etc.])

ERA DEG 8 – Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name: ______________________________
(Official name of provider's clearinghouse)

Clearinghouse Contact Name: ______________________________
(Name of a contact in the clearinghouse office for handling ERA issues)

Clearinghouse Telephone Number: ______________________________
(Telephone number of contact)

Clearinghouse E-mail Address: ______________________________
(An electronic mail address at which the health plan might contact the provider's clearinghouse)

ERA DEG 9 – Electronic Remittance Advice Vendor Information

Vendor Name: ______________________________
(Official name of provider's vendor)

Vendor Contact Name: ______________________________
(Name of a contact in vendor office for handing ERA issues)

Vendor Telephone Number: ______________________________
(Telephone number of contact)

Vendor Email Address: ______________________________
(An electronic mail address at which the health plan might contact the provider's vendor)

EFT DEG 8/ERA DEG 10

Reason for Submission: **New Enrollment** **Change Enrollment** **Cancel Enrollment**

Authorized Signature *(The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment).*

By signing below, provider acknowledges that the provider has read, agrees that it is subject to and agrees to comply with all terms and conditions for Quick Post Advisor enrollment, including those relating to the delivery of the services, which can be found at: https://enrollments.echohealthinc.com/TermAndCondition.aspx

Written Signature of Person Submitting Enrollment: ______________________________
(A [usually cursive] rendering of a name unique to a particular person used as confirmation of authorization and identity)

Printed Name of Person Submitting Enrollment: ______________________________
(The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment)

Submission Date ***(CCYYMMDD):*** ______________________________
(The date on which the enrollment is submitted)

Mail, fax or e-mail completed form (secure e-mail is recommended) to ECHO Health, Inc.

Mail to: **ECHO Health, Inc.**
810 Sharon Drive
Westlake, OH 44145

Fax: 440.835.5656

email: EDI@Echohealthinc.com