



1304 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 <ul style="list-style-type: none"> • Please complete all requested information BCBS of Mississippi Electronic Claims Information Worksheet <ul style="list-style-type: none"> • Please complete all requested information. 				
SEND REGISTRATION FORMS TO	Electronic Dental Services 1304 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	<table border="0"> <tr> <td>Electronic Dental Services Provider Enrollment</td> <td align="right">800-482-3518</td> </tr> <tr> <td>BCBS of Mississippi EDI Services</td> <td align="right">800-222-8046</td> </tr> </table>	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	Number	Rendering	NPI
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: Terri_____

Telephone Number: 651-480-8090_____ Fax Number: _____

Date: _____



**DENTAL ELECTRONIC CLAIMS INFORMATION
Worksheet**

CLEARINGHOUSE NAME: Emdeon Business Services - CT Dental	
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