BlueCross BlueShield of Illinois

Ancillary Provider Record ID Request Form

Use this form to request a provider record ID for billing purposes. Email this completed form to our **Network Operations Facility team** and attach all required supporting documentation.

A copy of these documents is required with your request:

- **Facility license** issued by your state or the license for your product or services
- **W-9 form** signed and dated
- **NPI confirmation** (the NPI should be linked to the Tax ID indicated above)

You'll receive a confirmation email when your provider record ID has been assigned.

Provider of Service Information			
Corporate Name (line 1 of W-9)		DBA Name (line 2 of W-9)	
Type of facility, entity, product or services			
Medicare number		National Provider Identifier	
Tax ID information		Federal Tax ID number	
Physical Location (location of practice)			
Address		Room/Suite	
City	State	ZIP	County
Phone Number ( ) -		Fax Number ( ) -	
Email Address			
Mailing Address (for claims payment)			
Address		Room/Suite	
City	State	ZIP	County
Phone Number ( ) -		Fax Number ( ) -	
Email Address			

Signature of Applicant or Authorized Representative

To the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to Blue Cross and Blue Shield of Illinois for the purpose of establishing a provider record ID for billing purposes.

Signature _____ Date _____

Title _____