



**ERA ENROLLMENT FORM
FOR PROVIDERS USING A CLEARINGHOUSE**

Please return completed form to edi.services@bcssc.com

I hereby authorize _____ to receive 835 Electronic Remittance Advices (ERAs)
(Name of clearinghouse)
 on my behalf. I am authorized to endorse this ERA enrollment form on behalf of my company, and I acknowledge that it is my responsibility to notify BlueCross BlueShield of South Carolina in writing if I wish to change or revoke this authorization.

BILLING PROVIDER TAX ID NUMBER	SUBMITTER ID NUMBER (BCBSSC Internal Use Only)
BILLING PROVIDER NPI NUMBER	BILLING PROVIDER CONTACT NAME/TITLE (Please Print)
BILLING PROVIDER NAME	BILLING PROVIDER CONTACT SIGNATURE (Required)
BILLING PROVIDER ADDRESS (Cannot be a P.O Box)	DATE
BILLING PROVIDER CITY/STATE/ZIP	BILLING PROVIDER PHONE NUMBER
	BILLING PROVIDER EMAIL ADDRESS
	CLEARINGHOUSE EMAIL ADDRESS (Optional)

For questions or concerns, contact BCBSSC EDI Services at edi.services@bcssc.com

