



BlueCross BlueShield
of Illinois



Provider Onboarding Form

User Guide for Groups/Clinics

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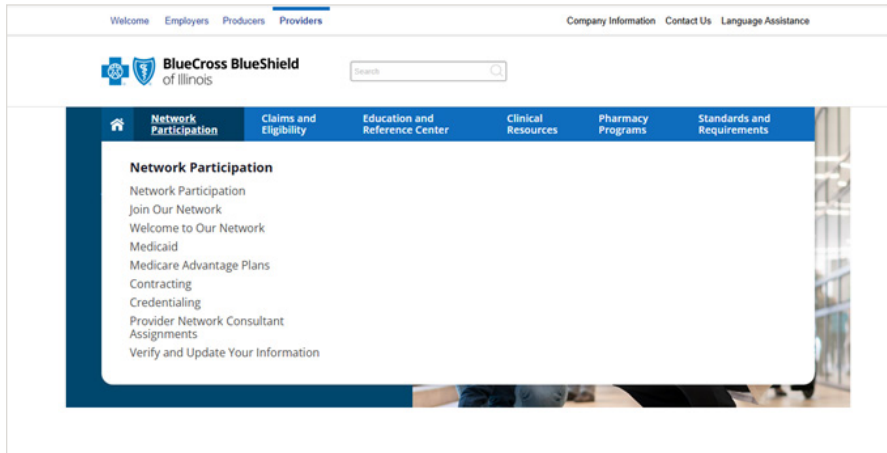
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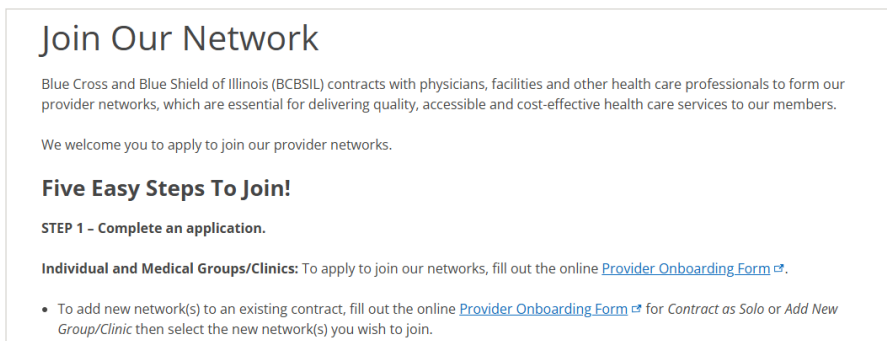
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Access the Provider Onboarding Online Form

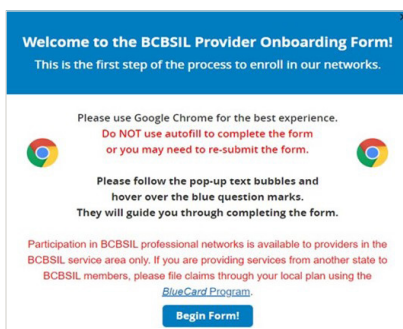
1. For best results use the **Google Chrome** browser.
2. To access the form from the Blue Cross and Blue Shield of Illinois website, click the **Providers** tab.



3. On the **Providers** tab, select the **Network Participation** tab and then select **Join Our Network** from the list of options.
4. Click the link to the **Provider Onboarding Form**.



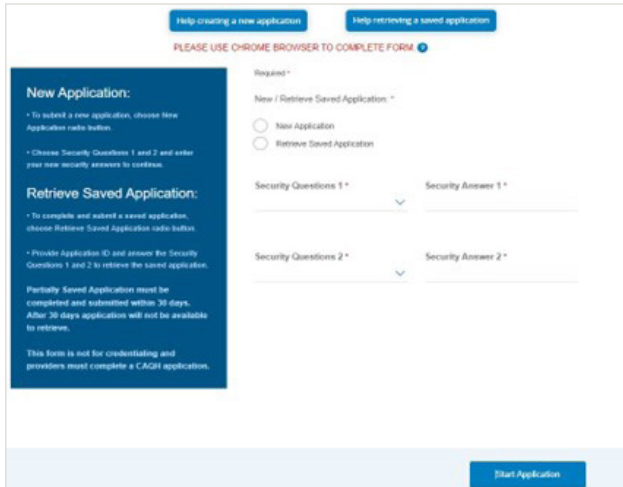
5. The Provider Enrollment form opens.
6. A disclaimer appears reminding you that there are additional processes outside of the enrollment process that need to happen before you are accepted as a participating provider.



New Application or Retrieve Saved Application

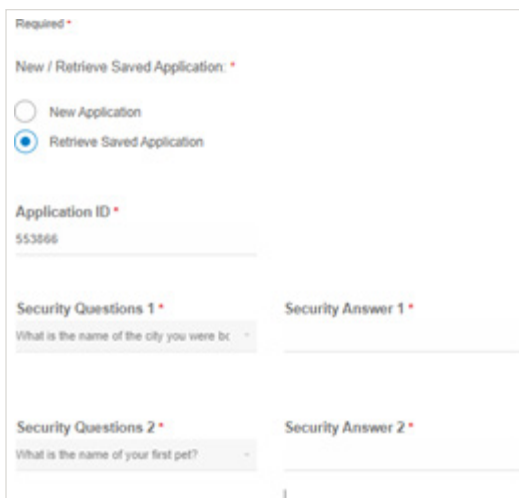
Note: Click the  for more information about the field.

1. Use Chrome Browser and do not use autofill to complete the form.
2. To start a new application, select the New Application button and answer the security questions.
3. To retrieve a Saved application, enter the application ID and answer the security questions using the same answers used to complete the initial form (capitalization and spelling matter!).



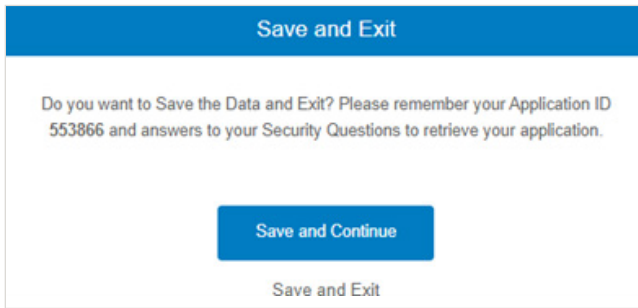
The screenshot shows a web form with two main sections: "New Application" and "Retrieve Saved Application". The "New Application" section includes instructions: "To submit a new application, choose New Application radio button." and "Choose Security Questions 1 and 2 and enter your new security answers to continue." The "Retrieve Saved Application" section includes instructions: "To complete and submit a saved application, choose Retrieve Saved Application radio button." and "Provide Application ID and answer the Security Questions 1 and 2 to retrieve the saved application." Below these instructions are two radio buttons: "New Application" (unselected) and "Retrieve Saved Application" (selected). There are also two sets of input fields for "Security Questions 1" and "Security Questions 2", each with a corresponding "Security Answer" field. A "Start Application" button is located at the bottom right.

A Partially Saved Application must be completed and submitted within 30 days. After 30 days, the application will not be available to retrieve.

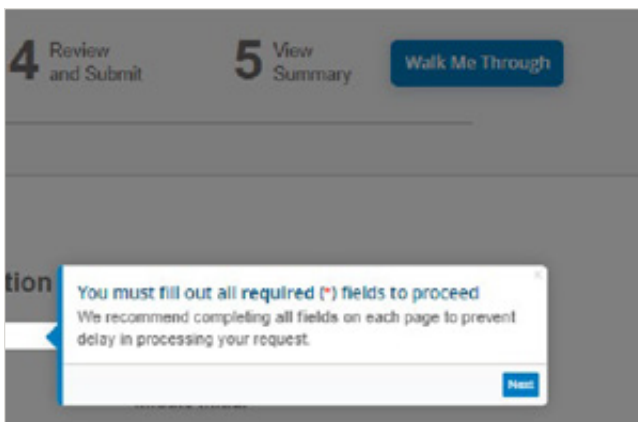


This close-up screenshot shows the "Retrieve Saved Application" radio button selected. The "Application ID" field contains the value "553866". The "Security Questions 1" field contains the text "What is the name of the city you were br". The "Security Questions 2" field contains the text "What is the name of your first pet?". The "Security Answer 1" and "Security Answer 2" fields are empty.

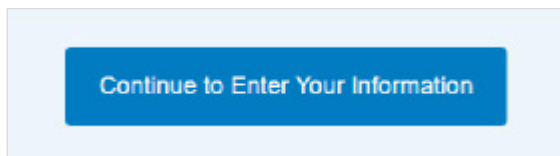
4. Click Save and Exit and be sure to note your Application ID number. You will need the Application ID and the answers to the security questions to log back in.



5. You may utilize the **Walk Me Through** button to get helpful tips as you complete the application. **You must fill out all required red asterisk (*) fields to proceed.**



6. Click the **Continue to Enter Your Information** button at the bottom of the screen.



Select Participation

This section allows you to enter submitter information and to select the type of participation you prefer.

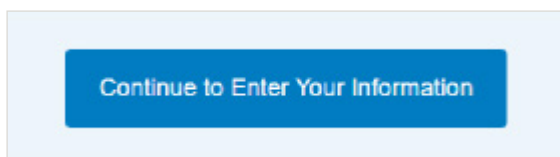
1. Enter the name and contact information of the person submitting the form. **All email correspondence related to this case will go to this contact.**

Select whether to **participate in network** or **participate out-of-network**.

If you are a dental provider and would like to be setup as out-of-network for medical claims, select **out-of-network**.

Submitter Information	
Required *	
First Name * EX. JOHN	Middle Initial OPTIONAL
Last Name * EX. SMITH	Suffix OPTIONAL
Email Address * EX. YOURNAME@EMAIL.COM	Telephone Number * EX. (234) 567-8901
Job Title/ Position * EX. SUPERVISOR	
Please select from one of the following options: *	
<input type="radio"/> Participate in-network <input type="radio"/> Participate out-of-network.	

2. Click the **Continue to Enter Your Information** button.



Next, you will have the option to select Add New Group/Clinic or Add Providers to an Existing Group/Clinic.

Add New Group/Clinic

Use this option if you are a brand-new group, have a new clinic with a new NPI, or wish to add a new network to your contract. For example, you wish to add Blue Choice PPOSM to your existing PPO contract.

[Click here](#) to advance to page 5 for instructions on **Add New Group/Clinic**.

Add Providers to an Existing Group/Clinic

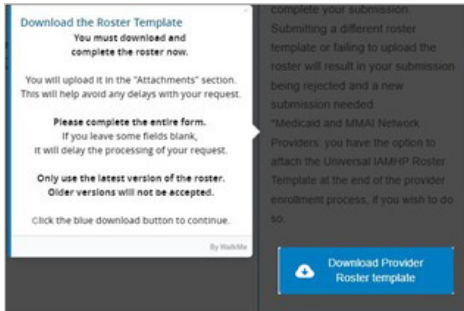
Use this option to add new providers to a group that is already contracted with BCBSIL.

[Click here](#) to proceed to page 7 for further instructions to **Add Provider to an Existing Group/Clinic**.

In Network – Add New Group/Clinic

Contracting is the process by which a group applies for and obtains participation in the Blue Cross and Blue Shield of Illinois network(s).

1. Please note that as a group/clinic, you will be required to complete the Roster.



2. Select the **Add New Group/Clinic** button if you intend to contract as a Group/Clinic.

Note: If you wish to participate in our networks as an LLC, please complete the "Add New Group/Clinic" application and provide your type 2 NPI.

Note: If you need to change demographics under your current contract, please use the **Demographic Change Form**.

Note: If your Tax ID is registered with the IRS as a group or corporation (PC, LLC, PLLC, S-Corp) you must contract with BCBSIL as a group and not a solo provider even if there is only one rendering provider within your group. Please refer to the 147-C form issued from the IRS.

Quick Tip: If you wish to contract with our commercial PPO plans, you must select PPO Network and you may select Blue Choice PPO. This network is narrower and differs in its reimbursement from the PPO network.

Quick Tip: If you wish to participate in Blue Cross Community Health PlansSM or Blue Cross Community MMAI (Medicare-Medicaid Plan)SM, you must be registered with the Illinois Department of Healthcare and Family Services on the Illinois Medicaid Program Advanced Cloud Technology file.

Quick Tip: BCBSIL does not contract directly with providers for HMO Illinois[®]; Blue Advantage HMOSM; and Blue Precision HMOSM networks. To participate in these networks, contact a Medical Group/IPA contracting with BCBSIL by viewing the **HMO Medical Group/IPA listing**. Click **Continue to Enrollment**.

Required *

Complete the form for: *

Contract as Solo Provider

Add New Group/Clinic

Add Providers to an Existing Group/Clinic

Network *

[Blue Choice PPO](#)

Provider Roster Instructions

Please download the template below and complete the Provider Roster. Once complete, upload in the Attachments section of this form. Please note that only the approved Roster template will be accepted, and it is required to complete your submission. Submitting a different roster template or failing to upload the roster will result in your submission being rejected and a new submission needed.

*Medicaid and MMAI Network Providers: you have the option to attach the Universal IAMHP Roster Template at the end of the provider enrollment process, if you wish to do so.

Download Provider Roster template

Which form should I fill out?

Required *

Complete the form for: *

Contract as Solo Provider

Add New Group/Clinic

Add Providers to an Existing Group/Clinic

Network *

[select](#)

FIND

Unselect all

Blue Choice PPO

Blue Cross Community Health Plan (Medicaid)

Blue Cross Community MMAI (Medicare-Medicaid Plan)

Blue Cross Medicare Advantage (HMO)SM (MA HMO) and Blue Cross Medicare Advantage (PPO)SM (MA PPO)

HMO Illinois[®], Blue Advantage HMOSM, Blue Precision HMOSM and Blue FocusCareSM networks

MyBlue Plus

Participation Provider Option (PPO) Professional Network

Download the roster template.

Roster Template

1. The roster template is an Excel document that will be filled out like a form. Please leave the roster in the Excel format and do not convert to other formats such as Numbers or PDF.
2. The roster template may be downloaded and completed at a later time. Please save the application and note your application ID to log back into the form without losing your data.
3. Please be sure to always download the most recent roster template as we make updates periodically and cannot accept outdated formats.
4. Complete one line (row) for each rendering provider/service location/specialty to be added.

Quick Tip: If a provider has two specialties, each specialty should be listed on its own line (row).

Note: Please be sure to scroll all the way to the right to view all columns.

	Effective Date	Tax ID	NPI Number	License	Medicare ID	Medicaid ID	Organization Name
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

5. Use the Standardized Template Grid Tab to find more details about information that is being requested.

	A	B
1	Standardized Template Definition Grid	
3	AE	Effective date= date provider should be effective with network
5	AG	Tax id =Provider's billing Tax (No special characters, just numbers xxxxxxxxx)
7	AI	NPI number= Individual provider's NPI (Type 1)
8	AJ	License = Medical state license number for the state in which you practice
9	AK	Medicare # = assigned number by CMS
10	AL	Medicaid # = assigned HFS number
11	AM	Organization name = Contracting entity's name (name on contract)
12	AN	Office name = Provider's office name
13	AO	First name = Provider's first name
14	AP	Last name = Provider's last name
15	AQ	Middle name = Provider's middle name
16	AR	Title= Provider's Degree (MD/DO/APN/PA, etc)
17	AS	Date of birth= Provider's birth date (xx/xx/xxxx)

Disclaimer

On the next screen you will see this **Disclaimer**. You must wait until your application has processed before you are considered a contracted provider.

Disclaimer

Please note completing this application does NOT mean that you are a participating provider. If you are requesting to be contracted, please note that your claims may pay out of network for services rendered until your contracts have been accepted, the credentialing process has been completed, and you receive an effective date. This form is not for credentialing and providers must complete a CAQH application.

[OK](#)

Click here to continue to **Enroll as a Provider**.

In Network – Add Providers to an Existing Group/Clinic

Use this option to add new providers to a group that is already contracted with BCBSIL. You will see the disclaimer below telling you to complete the roster with only the new provider/s that you are adding to the group. You will not list providers who are already linked to the group.

Disclaimer

Complete the BCBS Roster available on this page and include your new provider(s) information only on this template. Upload this template in the Attachments section of this form.

[Continue](#) [Cancel](#)

Complete the fields and download the roster template.

Required *

Complete the form for: *

Contract as Solo Provider

Add New Group/Clinic

Add Providers to an Existing Group/Clinic

Existing Group Practice Name *

SMITH & SMITH #1 SPECIALISTS

Existing Group Type 2 NPI (Organization) *

EX. 1234567890

Existing Group Tax Identification Number (TIN)/ Employer Identification Number (EIN) *

EX. 1234567890

Confirm Existing Group Tax Identification Number (TIN)/ Employer Identification Number (EIN) *

RE-TYPE THE TAX ID/EIN

Provider Roster Instructions

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*Medicaid and MMAI Network Providers: you have the option to attach the Universal IAMHP Roster Template at the end of the provider enrollment process, if you wish to do so.

[Download Provider Roster template](#)

Roster Template

1. You will be prompted to download the roster template. The roster template is an Excel document that will be filled out like a form. Please leave the roster in the Excel format and do not convert to other formats such as Numbers or PDF.
2. The roster template may be downloaded and completed at a later time. Please save the application and note your application ID to log back into the form without losing your data.
3. Please be sure to always download the most recent roster template as we make updates periodically and cannot accept outdated formats.
4. Complete one line (row) for each rendering provider/service location/specialty to be added.

Quick Tip: If a provider has two specialties, each specialty should be listed on its own line (row).

Note: Please be sure to scroll all the way to the right to view all columns.

	Effective Date	Tax ID	NPI Number	License	Medicare ID	Medicaid ID	Organization Name
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Use the Standardized Template Grid Tab to find more details about information that is being requested.

	A	B
1		Standardized Template Definition Grid
3	AE	Effective date= date provider should be effective with network
5	AG	Tax id =Provider's billing Tax (No special characters, just numbers xxxxxxxxx)
7	AI	NPI number= Individual provider's NPI (Type 1)
8	AJ	License = Medical state license number for the state in which you practice
9	AK	Medicare # = assigned number by CMS
10	AL	Medicaid # = assigned HFS number
11	AM	Organization name = Contracting entity's name (name on contract)
12	AN	Office name = Provider's office name
13	AO	First name = Provider's first name
14	AP	Last name = Provider's last name
15	AQ	Middle name = Provider's middle name
16	AR	Title= Provider's Degree (MD/DO/APN/PA, etc)
17	AS	Date of birth= Provider's birth date (xx/xx/xxxx)

Disclaimer

On the next screen you will see this **Disclaimer**. You must wait until your application has processed before you are considered a contracted provider.

Disclaimer

Please note completing this application does NOT mean that you are a participating provider. If you are requesting to be contracted, please note that your claims may pay out of network for services rendered until your contracts have been accepted, the credentialing process has been completed, and you receive an effective date. This form is not for credentialing and providers must complete a CAQH application.

OK

You will continue past the Disclaimer and complete section G Attachments. Please see page 14.

Enroll as a Provider

In this section you will provide important details about the individual provider or group/clinic and the services they will provide.

A. Group Practice Information

1. Open the section by clicking the arrow in the title bar.



2.

Group Practice Name * SMITH & SMITH #1 SPECIALISTS	Group Practice Start Date * MM/DD/YYYY
Type 2 NPI (Organization) * EX. 1234567890	Tax Identification Number (TIN) * EX. 1234567890
<input type="button" value="+ Add NPI"/>	<input type="button" value="Edit"/>
Group Website URL * ex. http://hcsc.com/who-we-are	Confirm Tax Identification Number(TIN) * RE-TYPE THE TAX IDENTIFICATION NUMBER
<input type="checkbox"/> N/A	

B. Additional Group Practitioner Information

1. Open the section by clicking the arrow in the title bar.

This section is where you will select the group type, specialty and any addition provider type, specialty, or sub-specialties that are needed.



2. Enter Provider Type/Specialty/Sub-Specialties

Primary Provider Type/ Specialty/ Sub-Specialties	
Primary Group Type * Select Provider Type	Primary Group Specialty * Select Specialty
Additional Provider Type/ Specialty/ Sub-Specialties	
Group Type	

Click **Continue to Enrollment**.

C. Office Physical Location

Please save your location information first before you continue to the next section. Accepting New Patients: if you are participating in specific networks, please include them in the Comments section.

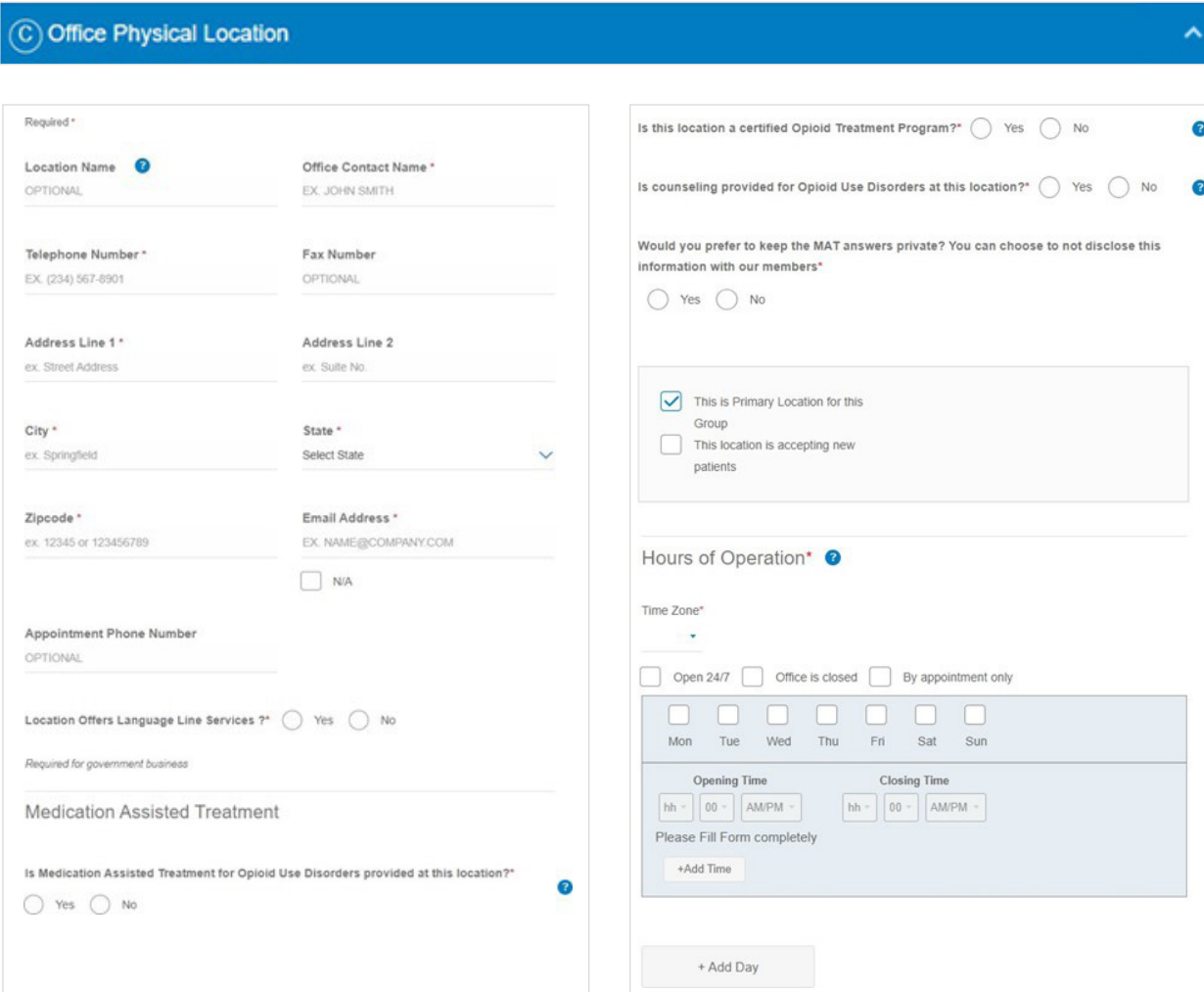
Note: Office Physical Location Address:

- A suggested Address will populate that is validated by the United States Postal Service.
- A PO BOX is not a valid entry for the Office Physical Location Address.

Note: Click the  for more information about the field.


1. Open the section by clicking the arrow in the title bar.

At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.



2.

Required *

Location Name  OPTIONAL

Office Contact Name * EX. JOHN SMITH


Telephone Number * EX. (234) 567-8901

Fax Number OPTIONAL

Address Line 1 * ex. Street Address

Address Line 2 ex. Suite No.

City * ex. Springfield

State * Select State 

Zipcode * ex. 12345 or 123456789

Email Address * EX. NAME@COMPANY.COM


N/A


Appointment Phone Number OPTIONAL


Location Offers Language Line Services ?* Yes No

Required for government business

Medication Assisted Treatment

Is Medication Assisted Treatment for Opioid Use Disorders provided at this location?* Yes No 

Is this location a certified Opioid Treatment Program?* Yes No 


Is counseling provided for Opioid Use Disorders at this location?* Yes No 

Would you prefer to keep the MAT answers private? You can choose to not disclose this information with our members?*

Yes No

This is Primary Location for this Group

This location is accepting new patients

Hours of Operation* 

Time Zone*

Open 24/7 Office is closed By appointment only

Mon	Tue	Wed	Thu	Fri	Sat	Sun
Opening Time		Closing Time				
hh -	00 -	AM/PM -	hh -	00 -	AM/PM -	

Please Fill Form completely

+Add Time

+ Add Day

Tips for Hours of Operation

- Add Time allows a maximum of 3 time sets.
- Times cannot overlap. Enter Hours of Operation.

Note: Be sure to enter the Time Zone and if this is the Primary Location for this provider. You may also select the Option to include this location is accepting new patients.

Americans with Disabilities Act (ADA)

Are the following standards in accordance with American with Disabilities Act? *

Yes No

If yes, please check at least one:

- | | |
|-------------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Site Accessible | <input type="checkbox"/> Exam Table |
| <input type="checkbox"/> Parking Accessibility | <input type="checkbox"/> Office Reception Area |
| <input type="checkbox"/> Exterior Building | <input type="checkbox"/> Close Proximity to Public Transportation |
| <input type="checkbox"/> Interior Building | <input type="checkbox"/> Restroom |
| <input type="checkbox"/> Exam Room | <input type="checkbox"/> Scale |
| <input type="checkbox"/> Accessible Grab Bars | <input type="checkbox"/> Wheelchair Accessible Hallways |
| <input type="checkbox"/> Accessible Lifts | <input type="checkbox"/> Wheelchair Accessible Service Counters |
| <input type="checkbox"/> Wheelchair Accessible Drinking Fountains | <input type="checkbox"/> Wide Doorways and Passageways |

Treating Categories

Does the provider treat the following? *

Please check at least one:

- | | |
|---------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Homebound | <input type="checkbox"/> Co-Occurring Disorders |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Blindness or Visually Impaired | <input type="checkbox"/> Physical Disabilities |
| <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Deafness or Hard of Hearing |
| <input type="checkbox"/> Serious Mental Illness | |

Treating Categories

Does the provider treat the following? *

Please check at least one:

- | | |
|---------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Homebound | <input type="checkbox"/> Co-Occurring Disorders |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Blindness or Visually Impaired | <input type="checkbox"/> Physical Disabilities |
| <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Deafness or Hard of Hearing |
| <input type="checkbox"/> Serious Mental Illness | |

Associations

Are you associated with:

If selected, all fields for each Association are required.

IPA (Independent Physician Association)

Name	Site Number	Tax ID
<input type="text"/>	EX. A12	EX. 1234567890

Confirm Tax ID
RE-TYPE THE TAX ID

PHO (Physician Hospital Organization)

Name	Site Number	Tax ID
<input type="text"/>	EX. A12	EX. 1234567890

Confirm Tax ID
RE-TYPE THE TAX ID

Health System

Name

Federally Qualified Health Center (FQHC)

Name	Site Number	Tax ID
<input type="text"/>	EX. A12	EX. 1234567890

Confirm Tax ID

RE-TYPE THE TAX ID

Community Mental Health Center (CMHC)

Name	Site Number	Tax ID
<input type="text"/>	EX. A12	EX. 1234567890

Confirm Tax ID

RE-TYPE THE TAX ID

Rural Health Clinic (RHC)

Name

Indian Health Services Facility

Name

Planned Parenthood

Name

Core Service Agency (CSA)

Name

- Once the save button is hit, it will condense and look like this. If you have any additional locations, you will select "Add New Location." If not, you will continue to the next section.

D. Additional Addresses & Contact Information

Enter information about the correspondence address, the billing address, and the administrative contact.

- Open the section by clicking the arrow in the title bar.

Note: You can use an existing address OR choose "use different address." If you select "use different address" you will be prompted to enter it. Do NOT use autofill to complete the form or you may need to re-submit the form.

E. Practice Information

This section contains information specific to the services the practice offers.

1. Open the section by clicking the arrow in the title bar.



2. Enter the **Telemedicine** and **Telehealth** information. At a minimum, complete all required (*) fields. However, if additional data is recommended be sure to enter it now to prevent a delay in the processing of your request.

Required *

Telemedicine

Do you render Telemedicine Services? * Yes No

Scheduling Telephone Number

EX. (234) 567-8901

Same Phone Number as Primary Office Physical Location

Telehealth

Do you render Telehealth Services? * Yes No

Lab Services

Do you render Laboratory Services? * Yes No

CLIA Number **Describe testing methodology**

EX. 12D4567890 EX. PHLEBOTOMY

F. Questionnaire

Note: This section will remain blank as it does not apply to our Group/Clinic Onboarding.

G. Attachments

In this section you will attach all the supporting documentation needed to complete your enrollment.

1. Attachments

Note: To contract as a New Group/Clinic, a W9 or IRS 147C is required. A Provider Roster is required. Please see the “Read Me” tab within the Roster for detailed instructions on how to add additional locations.

Note: The “Disclosure of Ownership & Control Interest form” is not required by BCBSIL.


Note: Independent Lab Providers: Complete the [Independent Lab Questionnaire](#) and attach here.

Do not add attachments until you are ready to submit the application. Attachments will not be saved if not submitted.

Browse your PC to attach the required files. Then, click on "Upload" to save the attachments within the enrollment form. File cannot exceed 5MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .pdf, .png, .txt, .xls, .xlsx. An Attachment filename must be less than or equal to 140 alphanumeric characters long.

[Download Roster](#)

Select Document Type: [?](#) [Which documents are required?](#)

 Upload Document

If you uploaded a document in error, click **Remove** to delete it.

Test Document.pdf	Remove
32 KB	

H. Comments

This section allows you to enter comments.

1. Open the section by clicking the arrow in the title bar.

Comments 

2. Type any comments, up to 2000 characters.

Optional

I. Attestation

This section serves as your confirmation that all information entered is accurate and complete.

1. Open the section by clicking the arrow in the title bar.

Attestation 

I certify that the information submitted within this form is accurate and complete.

Authorized Name * EX. JOHN SMITH	Title * EX. ADMINISTRATOR
Tax Identification Number * EX. 1234567890	Today's Date 10/17/2023
Confirm Tax Identification Number * RE-TYPE THE TAX IDENTIFICATION NUMBER	

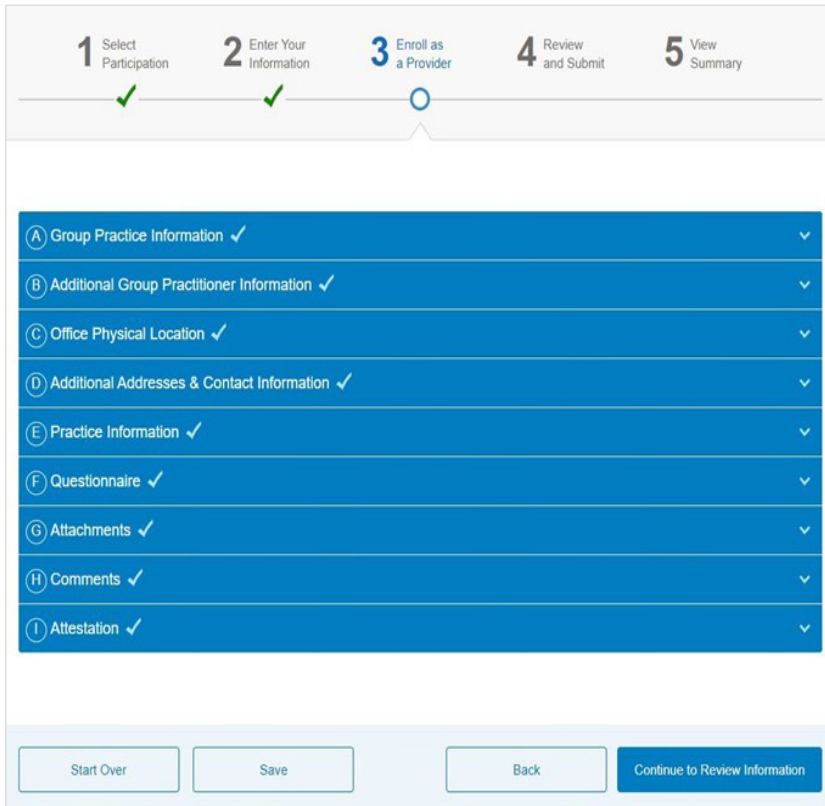
Continue to Review Information

Review and Submit

1. Open each section by clicking the blue title bar for that section. Once each section is complete, a checkmark will appear on the section header, and you will be able to proceed through the form. Example of a complete form. All



sections have a checkmark and the **Continue to Review Information** button is active.

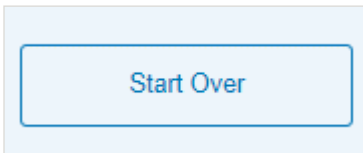
A screenshot of a form interface. At the top, a progress indicator shows five steps: 1. Select Participation (checked), 2. Enter Your Information (checked), 3. Enroll as a Provider (current step, indicated by a circle), 4. Review and Submit, and 5. View Summary. Below this is a list of sections, each with a blue header bar containing a letter in a circle, the section name, a checkmark, and a downward arrow. The sections are: (A) Group Practice Information, (B) Additional Group Practitioner Information, (C) Office Physical Location, (D) Additional Addresses & Contact Information, (E) Practice Information, (F) Questionnaire, (G) Attachments, (H) Comments, and (I) Attestation. At the bottom, there are four buttons: 'Start Over', 'Save', 'Back', and 'Continue to Review Information' (which is highlighted in blue).

Click **Continue to Review Information**

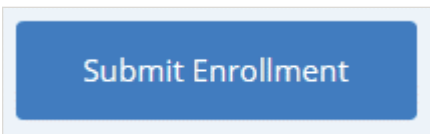
2. Example of incomplete application. Checkmarks are missing in Sections C and G and the **Continue to Review Information** button is greyed out. Please go back and complete the missing information. Once completed, the **Continue to Review** button will become active and change color to **blue**.

The screenshot shows a progress bar at the top with five steps: 1 Select Participation (checked), 2 Enter Your Information (checked), 3 Enroll as a Provider (active), 4 Review and Submit (greyed out), and 5 View Summary (greyed out). Below the progress bar is a list of sections: A Group Practice Information (checked), B Additional Group Practitioner Information (checked), C Office Physical Location (unchecked), D Additional Addresses & Contact Information (checked), E Practice Information (checked), F Questionnaire (checked), G Attachments (unchecked), H Comments (checked), and I Attestation (checked). At the bottom, there are four buttons: Start Over, Save, Back, and Continue to Review Information (greyed out).

3. If you want to abandon this enrollment and start over, click the **Start Over** button. You will lose all the data you have previously entered. You will receive a confirmation message asking if you are sure you want to do this.

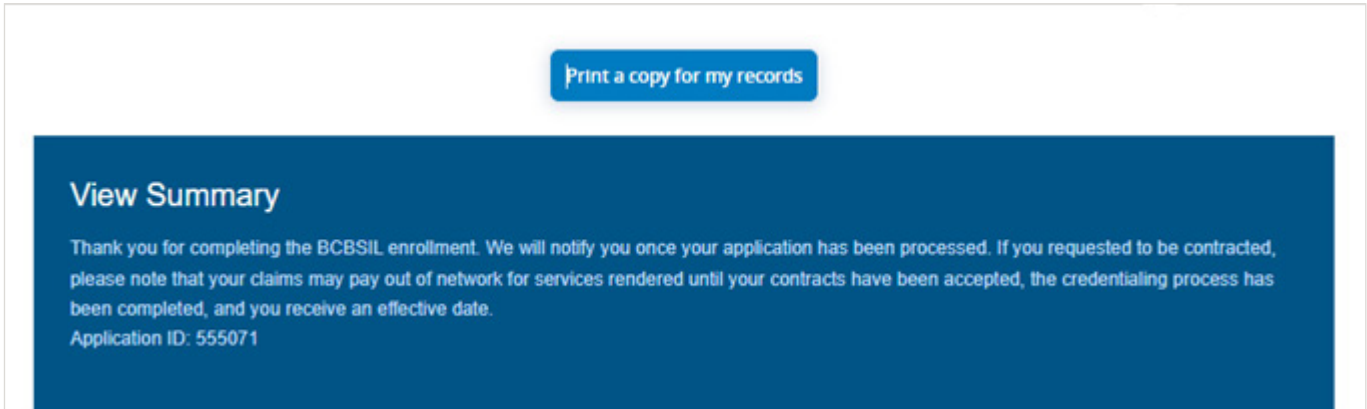


4. When you are sure all data is complete and correct, click **Submit Enrollment**.

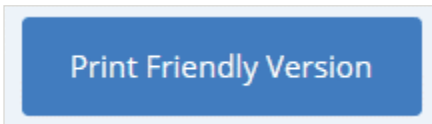


View Summary

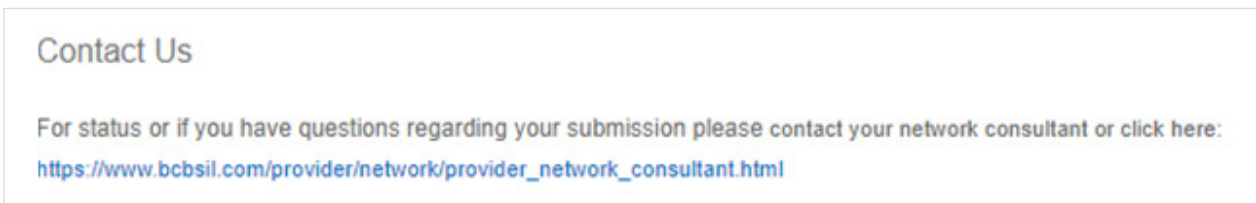
1. Once you have submitted your enrollment, you will receive a summary page that shows the data that you entered and submitted. The Application ID is listed in the View Summary header.



2. If you want to print the summary, click the **Print Friendly Version**. You can then print the summary or save it as a PDF.

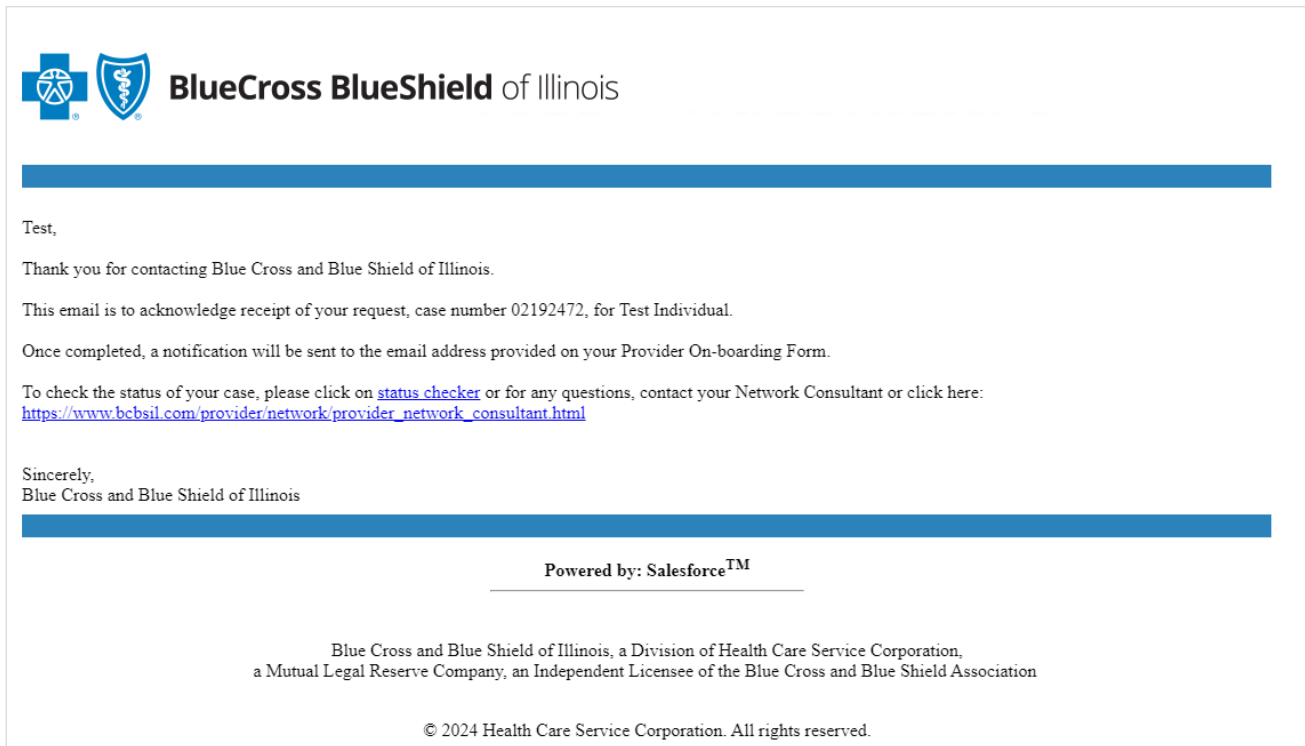


3. If you have questions about your enrollment, contact the team at Blue Cross and Blue Shield of Illinois using the **Provider Network Consultant Assignments list**.



Email Confirmation

1. An email confirmation will be sent from BCBSIL to the contact listed on the Submitter Information page. The case number is listed in the email. The Case number (not the application ID) should be used to check Case Status in the Case Status Checker or when emailing your assigned Provider Network Consultant or PNC Mailbox.



2. To check the status of your credentialing process, enter your NPI or license number in our **Credentialing Status Checker link**.

If you have questions about your enrollment, contact your assigned PNC or PNC Mailbox. **Professional PNC Assignment List**.

3. Once the application has completed processing and you are accepted as a provider into our Networks, you will receive a Welcome email with your networks and network effective dates. The Welcome email will be sent to the Submitter's email address.

Please check the Provider Finder® to ensure your information is accurate.

To check the Provider Finder, click on link to the **provider website**.

Scroll down to bottom, click on Provider Finder

If any Demographic Information needs to be updated, please complete the **Demographic Change Form**.

Sample Welcome Email

Dear [REDACTED]

Congratulations, your request to become a Blue Cross and Blue Shield of Illinois (BCBSIL) contracted provider has been approved.

Now that you are a network provider, we strongly encourage you to use all available electronic options. For more information on electronic data interchange (EDI) transactions, refer to the [Claims and Eligibility section](#) of our website.

Network Name	Network Effective Date						
BCE - Blue Choice PPO Preferred	2023-03-31	BCO - Blue Choice Options	2023-03-31	BCS - Professional Blue Choice PPO	2023-03-31	PPO - Preferred Provider Organization	2023-03-31

Please verify that all your information is correct on our [Provider Finder](#). If you need to change existing demographic information, complete the [Demographic Change Form](#). For any questions, contact your Network Consultant or click here: https://www.bcbsil.com/provider/network/provider_network_consultant.html.

To view the BCBSIL Provider Manual, access the Fee Schedule Request Form, or for general information, please visit our website at [bcbsil.com/provider](https://www.bcbsil.com/provider).

Need help getting started with BCBSIL, locate your assigned [Provider Network Consultant](#). We look forward to serving you!

Sincerely,
BCBSIL Network Operations

- If you are new to Blue Cross and Blue Shield of Illinois be sure to visit the [Welcome to Our Network page](#) on our website where we list helpful tools and resources to get you started.

Home | Network Participation | Claims and Eligibility

- Network Participation
- Join Our Network
- Welcome to Our Network**
- Medicaid
- Medicare Advantage Plans
- Contracting
- Credentialing
- Provider Network Consultant Assignments
- Verify and Update Your Information

5. The page lists many helpful resources for both new and established providers.

Welcome to Our Network

Welcome to Blue Cross and Blue Shield of Illinois! We're so glad you've chosen to join us as a participating provider.

Stop here if you haven't completed all the steps on our [Join Our Network](#) page.

Steps for Success

We know it can seem like a lot to take in at first. Here's a to-do list to help you start to settle in. Contact information is included at the bottom if you have questions.

Note: There may be differences for government programs (Medicaid/Medicare Advantage) and/or HMO members. Refer to your participating provider agreement for more information.

Step 1 – Sign Up for Introductory Training

We offer free training, including on demand orientation modules for new providers. Visit our [Webinars and Workshops page](#) for links, dates, times and online registration.

If you have questions related to the Provider Onboarding Form or the Onboarding Process, please contact your assigned PNC or PNC Mailbox. Be sure to include all provider information: Name, Tax ID, NPIs, Case number, etc. [Professional PNC Assignment List](#).

