



BlueCross BlueShield
of Illinois



Provider Onboarding Form

User Guide for Individual/Solo Providers

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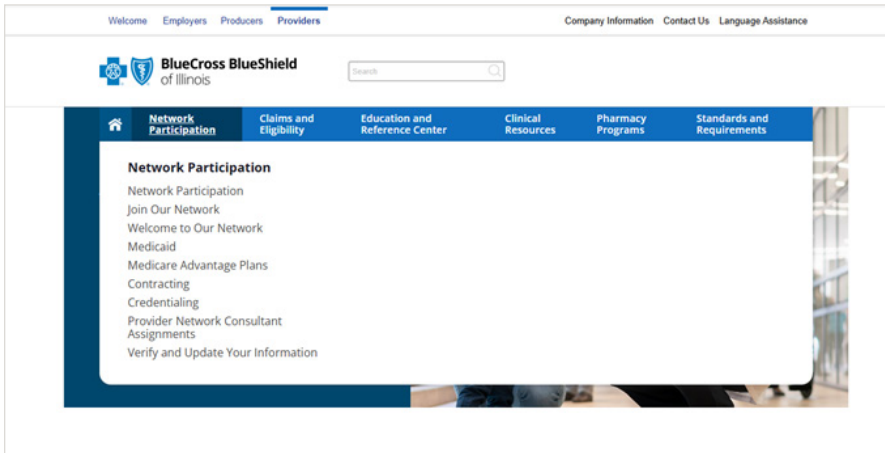
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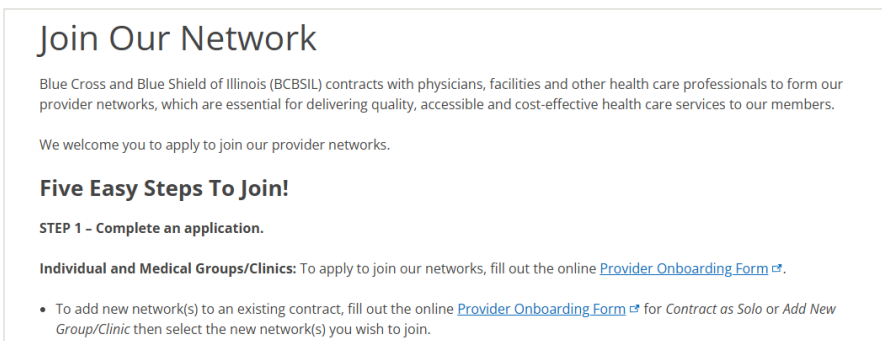
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Access the Provider Onboarding Online Form

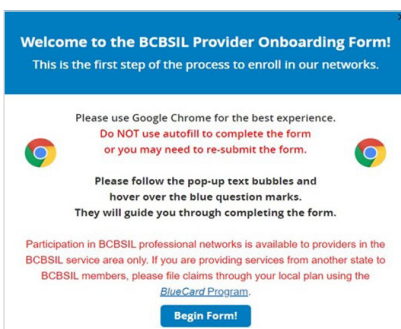
1. For best results use the **Google Chrome** browser.
2. To access the form from the Blue Cross and Blue Shield of Illinois website, click the **Providers** tab.



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**.



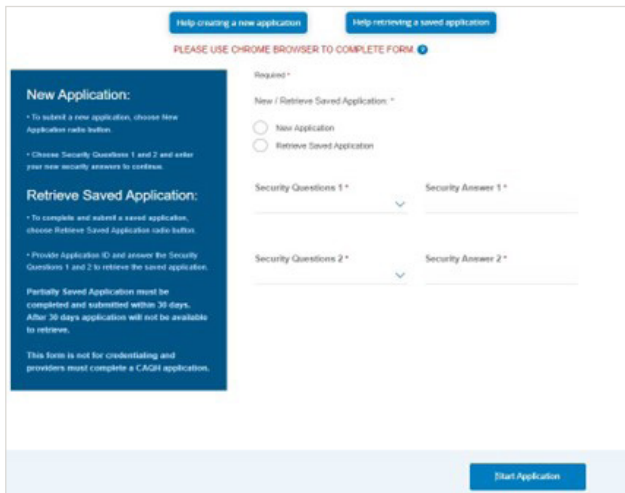
5. The Provider Enrollment form opens.
6. A disclaimer appears reminding you that there are additional processes outside of the enrollment process that need to happen before you are accepted as a participating provider.



New Application or Retrieve Saved Application

Note: Click the  for more information about the field.

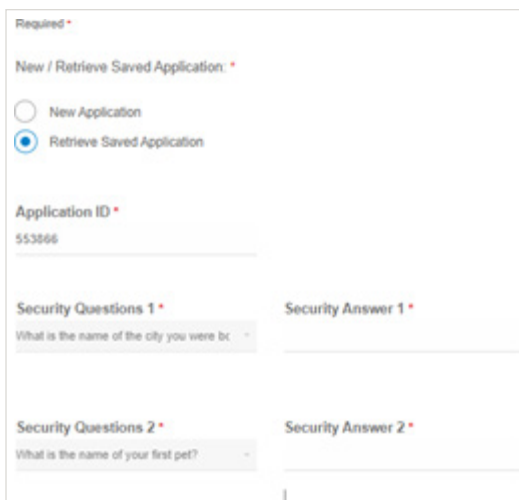
1. Use Chrome Brower and do not use autofill to complete the form.
2. To start a new application, select the New Application button and answer the security questions.



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 sets of security questions and answers. A 'Start Application' button is located at the bottom right.

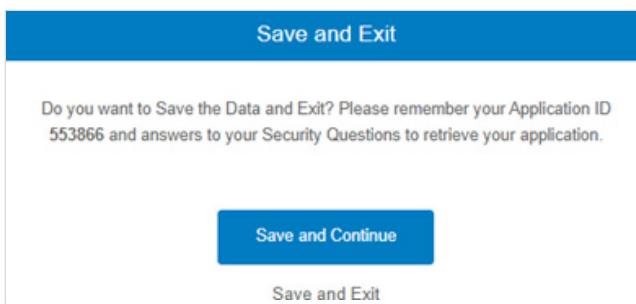
3. To retrieve a Saved application, enter the application ID and answer the security questions using the same answers used to complete the initial form (capitalization and spelling matter!)

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



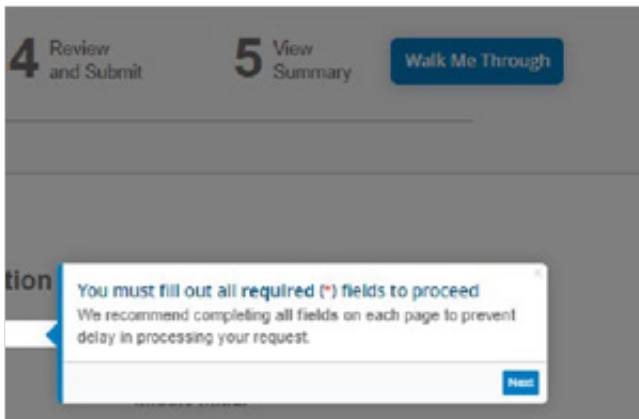
The screenshot shows the same form as above, but with 'Retrieve Saved Application' selected. The 'Application ID' field is filled with '553866'. The security questions are: 'What is the name of the city you were br...' and 'What is the name of your first pet?'. The 'Security Answer 1' and 'Security Answer 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.

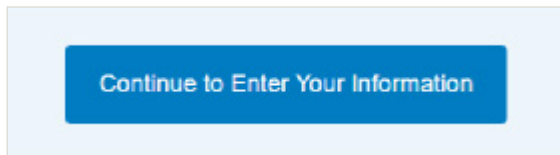


The screenshot shows a dialog box titled 'Save and Exit'. The text inside reads: 'Do you want to Save the Data and Exit? Please remember your Application ID 553866 and answers to your Security Questions to retrieve your application.' There are two buttons: 'Save and Continue' and 'Save and Exit'.

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.

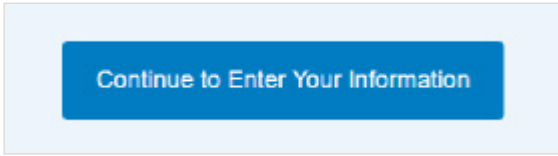
1. Enter the name and contact information of the person submitting the form. **All email correspondence related to this case will go to this contact.**

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.	

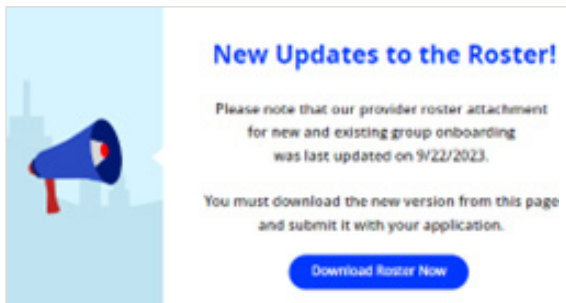
2. Click the **Continue to Enter Your Information** button.



In Network – Contract as a Solo Provider

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

1. Please note that as an individual provider you will not complete the Roster.



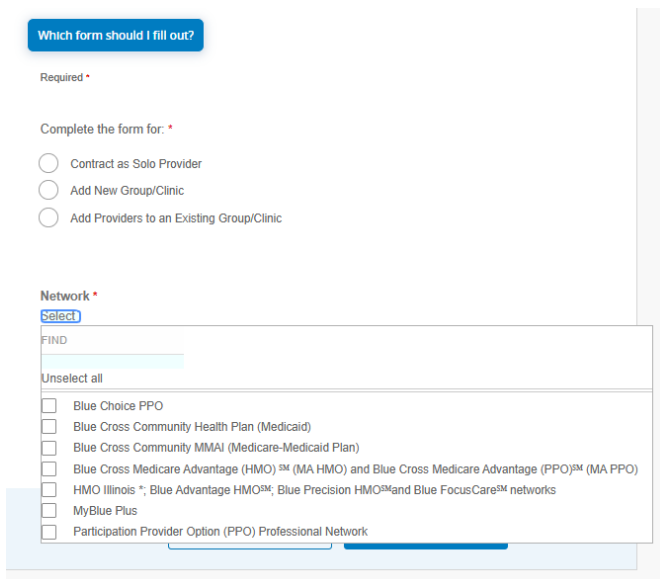
2. Select the **Contract as Solo Provider** button if you intend to contract as an Individual.

Note: If your Tax ID is registered with the IRS as a group or corporation (PC, LLC, PLLC, S-Corp) you must contract with Blue Cross and Blue Shield of Illinois 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.

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

Quick Tip: If you wish to contract with our commercial PPO plans, you must select PPO Network and you may select Blue Choice PPOSM. 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.



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 SM; Blue Advantage HMOSM; Blue Precision HMOSM and Blue FocusCareSM networks

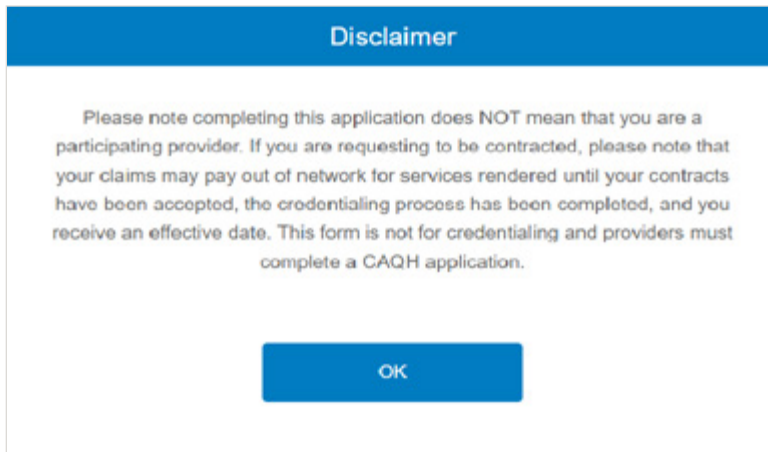
MyBlue Plus

Participation Provider Option (PPO) Professional Network

Click **Continue to Enrollment**.

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.



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. Practitioner Information

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



2. Indicate if the provider is currently in a **residency program**.

Note: If a user selects that they are in a residency program they will not be able to proceed with the form.

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.

3. Select the primary provider type and primary provider specialty from the drop-down list.

Credentialing is the process by which Blue Cross and Blue Shield of Illinois reviews and validates the professional qualifications of physicians and certain other providers who apply for participation in our networks, ensuring they meet our professional standards.

Note: If the provider type requires Credentialing, you will be prompted for the Council for Affordable Quality Healthcare® number. The system checks to validate the number entered. [Learn more](#).

Credentialing is required for Professional Provider Types: MD, DO, PsyD, PHD, AUD, BCBA, OD, DC, CNM, DPM, LCSW, LCPC, LMFT, PA, APN, ANP, CNP, CNS, LAC, DN and RD.

Enter a valid IL license or IN license if you are in Lake County, IN.

Quick Tip: Enter the Tax ID twice. Once the TAX ID is entered into the Confirm Tax Identification field, be sure click out of the box to ensure it matches the first TIN entered.

Note: An individual provider may contract under their Social Security Number or for more security, their IRS issued Tax ID.

Required *

Is the provider currently in a residency program? * Yes No ?

Primary Provider Type * **Primary Provider Specialty ***

Select Provider Type Select Specialty ?

Board Certified

CAQH Number
EX. 1234567890

License Number *
EX. 1234567890

Tax Identification Number (TIN) *
EX. 1234567890

Confirm Tax Identification Number (TIN) *
RE-TYPE THE TAX IDENTIFICATION NUMBER

B. Personal Information

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.

B Personal Information

2. Enter Provider Information

Required *

Same as Submitter

First Name * **Middle Initial**
EX. JOHN OPTIONAL

Last Name * **Suffix**
EX. SMITH OPTIONAL

Title(s) * **Date of Birth ***
 MM/DD/YYYY

Gender *
 Male Female

Click **Continue to Enrollment**.

C. Additional Personal & Practitioner Information


The section contains additional personal information about the individual. 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.


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.

Additional Personal & Practitioner Information


2.  Required *

Applying As* 

Primary Care Physician/ Provider

Specialty Care Physician/ Provider

Additional Provider Type/ Specialty/ Sub-Specialties

Provider Type 

Medical College Name
EX: ALPHANUMERIC

Medical College Start Date
MMDD/YYYY

Medical College End Date
MMDD/YYYY

Residency Hospital Name
EX: ALPHANUMERIC

Residency Start Date
MMDD/YYYY

Residency End Date
MMDD/YYYY

Medicare Number
EX: ALPHANUMERIC

Medicaid Number
EX: 9-12 NUMERICAL NUMBER

3. **Note:** If the NPI number is invalid, you will receive a message. You will have to attach your NPI Enumerator Response in the Attachments section of this enrollment form.

If the NPI number is not recognized by nppes.com, the system will not allow you to submit the application.

4. **Quick Tip:** Cultural Competency Training is recommended for providers requesting participation in Medicaid networks.

DEA Number
EX. 1-9 ALPHANUMERICAL NUMBER

Hospital Admitting Privileges
HOSPITAL NAME FOR PRIVILEGES

Admitting Hospital Type 2 NPI
EX. 1234567890

+ Add Hospital Admitting Privileges

Ambulatory Surgery Center Privileges
EX. 1234567890

Language(s) Spoken
[Select](#)

Cultural Competency Training Completed?*

Yes No

Completion Date
MM/DD/YYYY

Type 1 NPI (Individual) *
EX. 1234567890

Social Security Number
EX. 123456789

Confirm Social Security Number
RE-TYPE THE SOCIAL SECURITY NUMBER

Ethnicity

D. Office Physical Location

Enter information about the physical location(s) of the office(s).

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



2. If you have multiple offices in one Street Address, be sure to include the Suite Number for each.

Note: A PO Box is not a valid entry for the Office Physical Location Address.

Note: You can enter multiple locations.

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 <input type="checkbox"/> N/A
Appointment Phone Number * EX. (234) 567-8901	Start Date at This Location * MM/DD/YYYY

Location Offers Language Line Services? * Yes No

Required for government business

Lactation Service

Do you provide lactation / breastfeeding support services, including counseling and education? *

Yes No

3. 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.

Medication Assisted Treatment

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

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

Is Physician authorized to dispense Medication Assisted Treatment (MAT) for Opioid Use Disorders? * Yes No

Would you prefer to keep the MAT answers private? You can choose to not disclose this information with our members * Yes No

Service(s) performed at this location (check all that apply)

- Patient's Home Visits Only
- Patient's Work Place Visits Only
- Hospice Visits Only
- Nursing Home Visits Only
- Skilled Nursing Facility Visits Only

Service(s) performed at this location
OPTIONAL

Supervising Physician
OPTIONAL

+ Add Service

Supervising Physician Type 1 NPI Number
EX. 1234567890

Supervising Physician Specialty
Select Specialty

4. 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.

This is Primary Location for this Provider
 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	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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 three time sets.
- Times cannot overlap.

Time Zone*
CST

Open 24/7 Office is closed By appointment only

Mon	Tue	Wed	Thu	Fri	Sat	Sun	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Opening Time	Closing Time						
09 - 00 - AM	05 - 00 - PM						
hh - 00 - AM/PM	hh - 00 - AM/PM					Delete Time	
Please completely fill out this section							
+Add Time							

- Add Day function allows a maximum of 7 days. 
- Each day can be used only once in a single time block.

Time Zone*
CST

Open 24/7 Office is closed By appointment only

Mon	Tue	Wed	Thu	Fri	Sat	Sun	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Opening Time	Closing Time						
09 - 00 - AM	05 - 00 - PM						
hh - 00 - AM/PM	hh - 00 - AM/PM					Delete Time	
Please completely fill out this section							
+Add Time							

Office is closed By appointment only

Mon	Tue	Wed	Thu	Fri	Sat	Sun	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Opening Time	Closing Time						
hh - 00 - AM/PM	hh - 00 - AM/PM						
Please completely fill out this section							
+Add Time							

If any of the network(s) selected in the **Enter Your Information** section are Medicare or Medicaid networks, the Treating Categories are required.


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	

5. Please enter details, if applicable.

Federally Qualified Health Center (FQHC)

Name Site Number Tax ID

EX. A12 EX. 1234567890

Confirm Tax ID

RE-TYPE THE TAX ID

Community Mental Health Center (CMHC)

Name Site Number Tax ID

EX. A12 EX. 1234567890

Confirm Tax ID

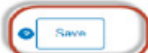
RE-TYPE THE TAX ID

Rural Health Clinic (RHC) Indian Health Services Facility

Name Name

Planned Parenthood Core Service Agency (CSA)

Name Name



Click **Save**.

Note: It is important that you do this after creating each location. You will not be able to proceed with the enrollment process until the location is saved.

6. Once you save the location, a **Card View** is created.

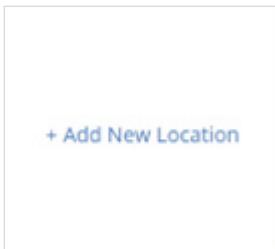
Note: The  indicates that this location is the Primary Location.

If you need to edit the information, click . Don't forget to save your changes.

Review the information.

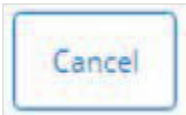


7. If you need to add additional locations, click the **Add New Location** button.

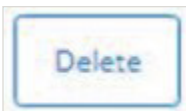


8. Complete the applicable information and click **Save**.

9. **Cancel** button cancels your changes and returns you to the Card View.



Delete button deletes the location.



E. Additional Addresses & Contact Information

Enter any additional addresses and contact information for the locations.

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



2. You can enter different addresses for each of the address requirements or use the same address(es). Designate which address to use by selecting the appropriate option for each address type.

If you chose to use a different address, you are prompted to enter it.

Correspondence Address * ⓘ	
<input type="radio"/> Use different address	<input type="radio"/> Same as Primary Office Physical Location
Billing Address *	
<input type="radio"/> Use different address	<input type="radio"/> Same as Primary Office Physical Location
<input type="radio"/> Same as Correspondence Address	
Credentialing Address *	
<input type="radio"/> Same as Primary Office Physical Location	<input type="radio"/> Same as Correspondence Address
<input type="radio"/> Same as Billing Address	<input type="radio"/> Use different address

3. Enter the information for the **Administrative Contact**.

Administrative Contact *	
Name * ex. John Smith	Job Title/Position * ex. Supervisor
Telephone Number * ex. (234) 567-8901	Fax Number Optional
Email Address * ex. name@company.com	
<input type="checkbox"/> N/A	
Comments Optional	

F. 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

Scheduling Telephone Number *
EX. (234) 567-8901

Same Phone Number as Primary Office Physical Location

What Modality do you use? Please select one *

Telehealth available via audio only Telehealth available via audio and video

What Types of Services do you offer via Telehealth? Please select one *

<input type="checkbox"/> Telehealth - Medical Care	<input type="checkbox"/> Telehealth - Other Medical Items or Services
<input type="checkbox"/> Telehealth - Consultation	<input type="checkbox"/> Telehealth - Hearing Items or Services
<input type="checkbox"/> Telehealth - Hospice	<input type="checkbox"/> Telehealth - Outpatient Mental Health Treatment Limitation
<input type="checkbox"/> Telehealth - Vision Items or Services	<input type="checkbox"/> Telehealth - Physical Therapy
<input type="checkbox"/> Telehealth - Occupational Therapy	

Telehealth w/Family Caregiver in Different Place? Yes No


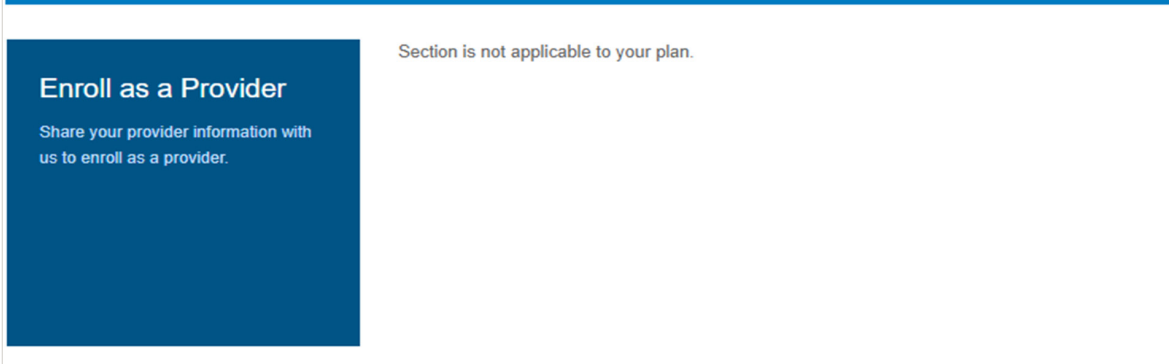
Lab Services

Do you render Laboratory Services? * Yes No

CLIA Number
EX. 12D4567890

Describe testing methodology
EX. PHLEBOTOMY

G. Questionnaire – Section is not applicable to your plan

1. 
The screenshot shows a blue header bar with a "Questionnaire" label and a checkmark icon. Below it, a dark blue box contains the text "Enroll as a Provider" and "Share your provider information with us to enroll as a provider." To the right of this box, the text "Section is not applicable to your plan." is displayed.

H. Attachments

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

1. 

2. Select the **document type** from the list.

Required Documents:

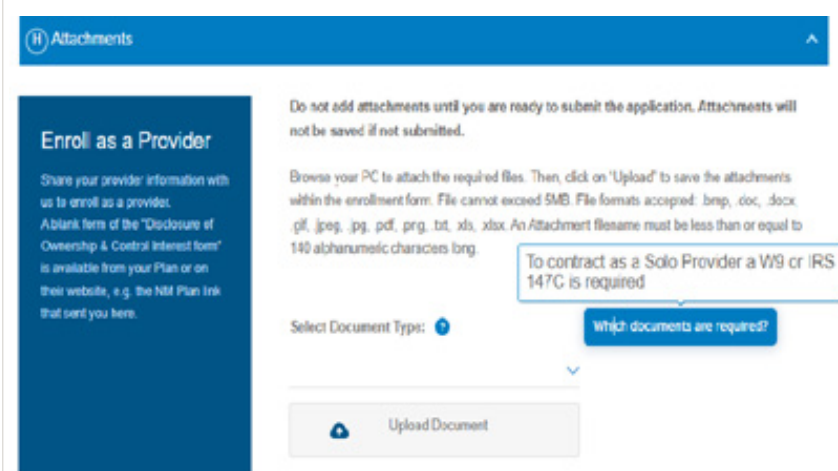
All the document types are not required. We require a W-9 or IRS 147C for Individual provider enrollment.

3. Click the Upload **Document button**.

Locate the file on your hard drive and upload. Repeat steps 2-4 for each document.

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

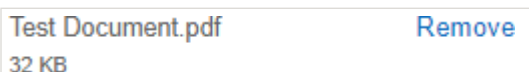
Note: Be sure you are attaching the correct document to the document type.



Attachment tips

- Only attach the documents requested in the list.
- Size cannot exceed 5MB.
- File names cannot exceed 140 characters.
- File types accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .pdf, .png.

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



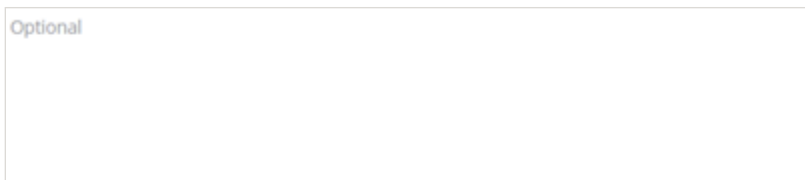
I. Comments

This section allows you to enter comments.

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

A blue horizontal bar with the word "Comments" on the left and a white downward-pointing arrow icon on the right, enclosed in a red square box.

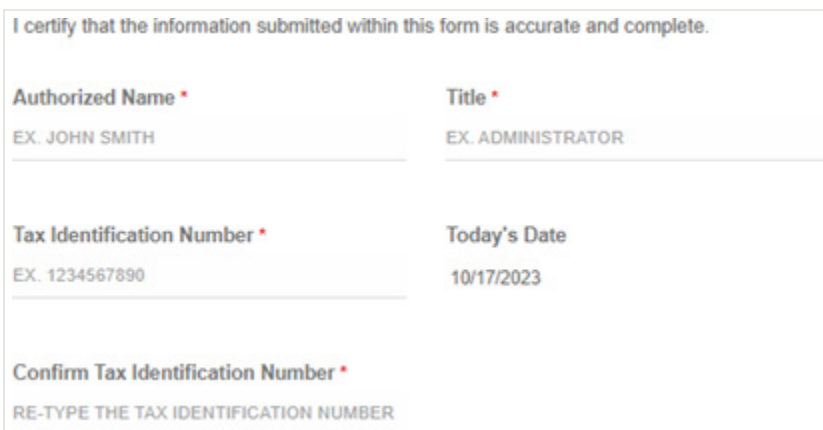
2. Type any comments, up to 2000 characters.

A large, empty white rectangular text area with the word "Optional" in the top-left corner.

J. Attestation

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

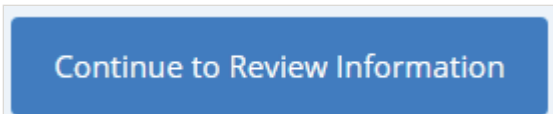
1. Open the section by clicking the arrow in the title bar.

A blue horizontal bar with the word "Attestation" on the left and a white downward-pointing arrow icon on the right, enclosed in a red square box.A white rectangular form area containing the following text:

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	

Review and Submit

A blue rectangular button with the text "Continue to Review Information" in white.

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.

A blue horizontal bar with the text "Practitioner Information" on the left, a white checkmark icon to its right, and a white upward-pointing arrow icon on the far right.

2. Example of a complete form. All sections have a checkmark and the **Continue to Review Information** button is active.

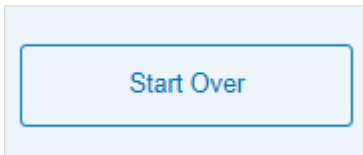
The screenshot shows a progress bar at the top with five steps: 1 Select Participation (checked), 2 Enter Your Information (checked), 3 Enroll as a Provider (active), 4 Review and Submit, and 5 View Summary. Below the progress bar is a list of ten sections, each with a lettered icon, a title, a checkmark, and a dropdown arrow. All sections (A-J) have checkmarks. At the bottom, there are four buttons: 'Start Over', 'Save', 'Back', and 'Continue to Review Information'. The 'Continue to Review Information' button is highlighted in blue, indicating it is active.

Click **Continue to Review Information**

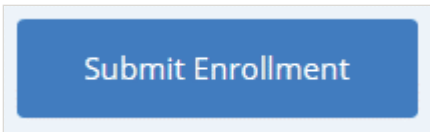
3. Example of incomplete application. Checkmarks are missing in Sections C, D, E, F, H and J and the **Continue to Review Information** button is greyed out. Please go back and complete the missing information. Once completed, the **Continue to Review** button will become active and change color to **blue**.

The screenshot shows the same application form interface as above, but with several sections missing checkmarks: C, D, E, F, H, and J. The 'Continue to Review Information' button at the bottom is greyed out, indicating it is inactive. The 'Save' button has a question mark icon next to it, suggesting a warning or error state.

4. 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.

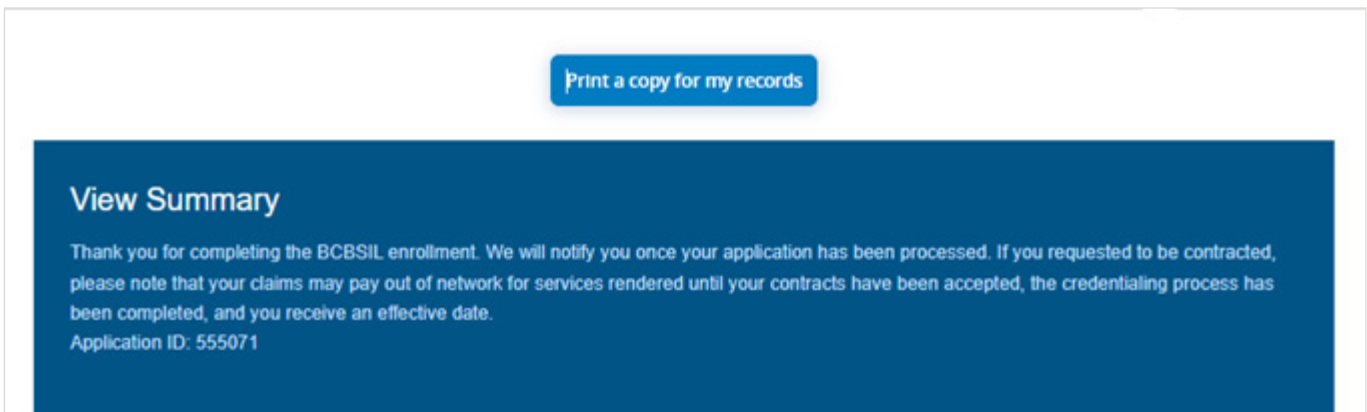


5. When you are sure all data is complete and correct, click **Submit Enrollment**.

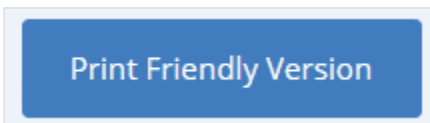


View Summary

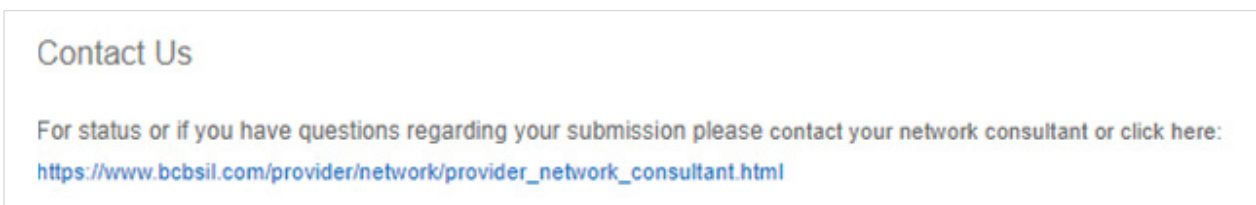
1. Once you have submitted your enrollment, you will receive a summary page that shows the data that you entered and submitted. The Application ID is listed in the View Summary header.



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.

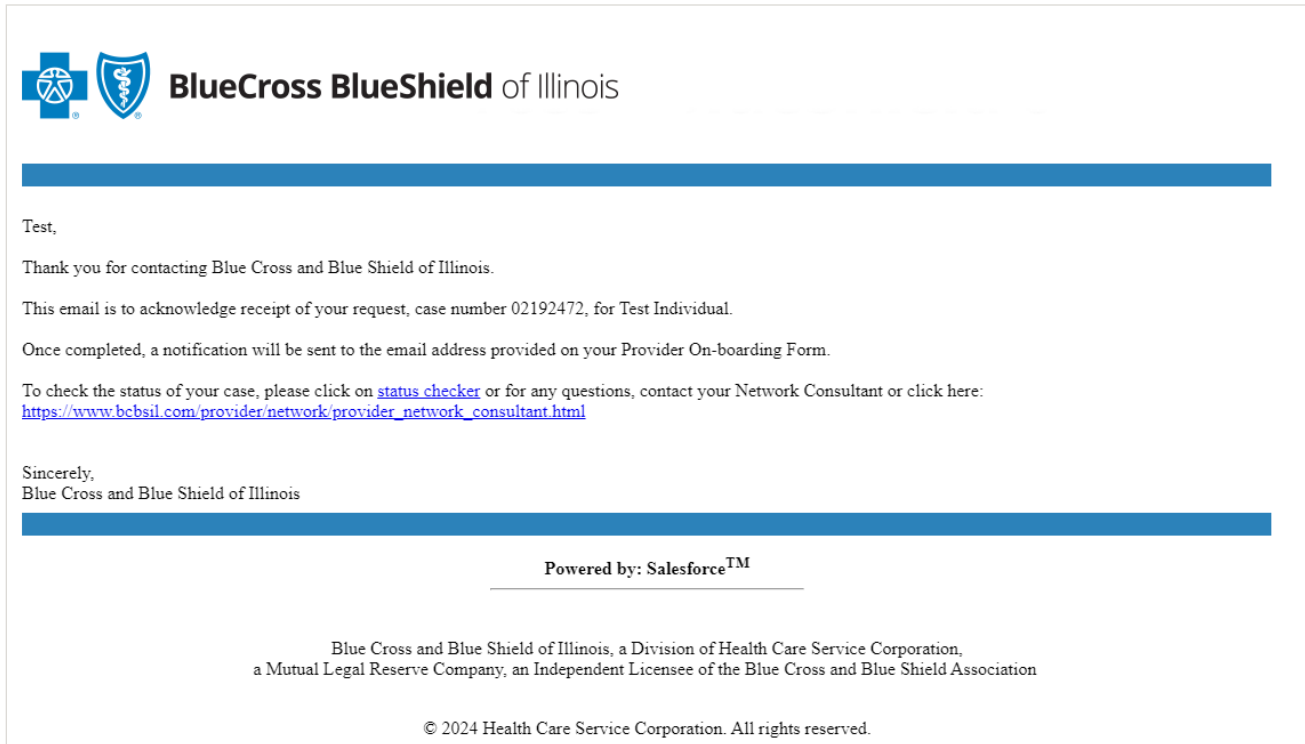


3. If you have questions about your enrollment, contact our team using the **Provider Network Consultant Assignments list**.



Email Confirmation

1. An email confirmation will be sent from Blue Cross and Blue Shield of Illinois 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

4. 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.

The screenshot shows a website navigation bar with two main sections: "Network Participation" and "Claims and Eligibility". The "Network Participation" dropdown menu is open, displaying the following items:

- 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.**

The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry, no matter how small, should be recorded to ensure the integrity of the financial statements. This includes not only sales and purchases but also expenses, income, and transfers between accounts.

Next, the document outlines the process of reconciling bank statements with the company's records. This involves comparing the bank's record of transactions with the company's ledger to identify any discrepancies. Common reasons for discrepancies include timing differences, such as deposits in transit or outstanding checks, and errors in recording or omission of transactions.

The document then provides a detailed explanation of the accounting cycle, which consists of eight steps: 1) identifying and recording transactions, 2) journalizing, 3) posting to the ledger, 4) determining debits and credits, 5) preparing a trial balance, 6) adjusting entries, 7) preparing financial statements, and 8) closing the books. Each step is described in detail, including the necessary journal entries and ledger postings.

Finally, the document discusses the preparation of financial statements, including the balance sheet, income statement, and statement of cash flows. It explains how these statements are derived from the accounting records and how they provide a comprehensive view of the company's financial performance and position.