



An independent licensee of the  
Blue Cross and Blue Shield Association

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

***Please return completed form to [edi.services@bcbsc.com](mailto:edi.services@bcbsc.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<sup>®</sup> BlueShield<sup>®</sup> of South Carolina in writing if I wish to change or revoke this authorization.

BILLING PROVIDER TAX ID NUMBER	SUBMITTER ID NUMBER (BlueCross Internal Use Only)
BILLING PROVIDER NPI NUMBER	BILLING PROVIDER CONTACT NAME/TITLE (Please Print)
BILLING PROVIDER NAME	BILLING PROVIDER CONTACT SIGNATURE
ADDRESS	DATE
CITY/STATE/ZIP	PHONE NUMBER
	EMAIL ADDRESS

For questions or concerns, contact BlueCross EDI Services at [edi.services@bcbsc.com](mailto:edi.services@bcbsc.com)

