



THIN
The Health Information Network

PROVIDER ENROLLMENT 'UPDATE' FORM

**SECTION 1
PROVIDER DATA**

PROVIDER NAME:
PROVIDER ADDRESS:
CITY: ST: ZIP:
PRIMARY CONTACT AT THE PROVIDER'S OFFICE:
PHONE NUMBER: FAX:
EMAIL ADDRESS:
BLUE CROSS AND BLUE SHIELD PROVIDER ID:
COMMERCIAL PROVIDER # (tax ID):
MEDICARE PROVIDER ID: MEDICAID PROVIDER ID:
Check the following which are applicable:
<input type="checkbox"/> *Provider is the Direct Submitter of Data (Complete Sections 1&2)
<input type="checkbox"/> *Provider is With Billing Service/Clearinghouse (Complete Sections 1&3 at a minimum)
<input type="checkbox"/> *Provider is With an Existing THIN Submitter (Complete Sections 1&3 at a minimum)
*Submitter must have a Submitter Trading Partner Agreement on file. To obtain a copy of the Submitter Enrollment Packet, please visit our website at www.bcbsil.com and select Electronic Commerce/Forms

**SECTION 2
EDI SOFTWARE VENDOR DATA**

COMPANY NAME: VENDOR CODE:
PRIMARY CONTACT: EMAIL:
PHONE NUMBER: FAX NUMBER
Indicate the format & version you support: T0301 (NSF) ___ ANSI 4010A1 ___

SECTION 3
 EDI BILLING SERVICE CLEARINGHOUSE DATA OTHER

COMPANY NAME:
PRIMARY CONTACT:
PHONE NUMBER: FAX NUMBER:
EMAIL ADDRESS:
THIN SUBMITTER ID:
Indicate the format & version you submit: T0301 (NSF) ___ ANSI 4010A1 ___

SIGNATURE: _____ **DATE:** _____

PLEASE FAX THE COMPLETED DOCUMENT TO THIN INC. (IL) at 312-861-0149.

If you have any questions, please contact the EDI Hotline at 877/EDI-THIN - Illinois Press 1 (8:30am – 4:30pm CST).