

USER MAINTENANCE REQUEST FORM

Entity Provider Name:			
Entity Tax ID Number:	Affiliate Provider NPI (Optional):		
The Blue <i>e</i> Administrator is responsible creating and removing users. The Administrator person must have a unique user account Network Agreement. Billing / credential information. Granting Blue <i>e</i> access to	inistrator is responsib int. Sharing / Reassign ling companies are ac	le for ensuring the account ling a Blue e User ID is in v dvised not to register their o	information is up to date. Each iolation of the Blue <i>e</i> Interactive organizations under their client's
Please ADD the following <u>NEW</u> user		:	
USER INFORMATION (for Blue	•		
USER NAME (First, Middle Initial, Last)	JOB RESPONSIBILITY (e.g., Registration, Billing, Human Resources, EFT*)		USER E-MAIL ADDRESS
*Please see the amended Blue e Network Agreer Please MODIFY the following existing			
USER NAME (First, Middle Initial, Last)	USER ID	ACCESS REQUESTED	USER E-MAIL ADDRESS
Please DELETE the following users	rom Blue <i>e</i> access:	<u> </u>	I
USER NAME		USER NAME	
(First, Middle Initial, Last)		(First, Middle Initial, Last)	
Required Information:			
In order to verify your identity as a Blue Cross NC provider, please provide the following information: Date of most reflect to the following information: Date of most reflect to the following information:			
Note: Failure to supply this information.			
Please complete the following RE			
D / N			
Requestor's Name: Business		Business	
Phone Number:	EXT:	FAX Number	r:
Business Email Address:			
Authorized Signature and Printed Name:			Date: