Direct Claim Submission Enrollment Form

Thank you for your interest in direct claim submission. Fields with an asterisk (*) are required. We cannot fulfill the enrollment process if all the required fields are not completed. Please complete this form and fax it to 410-505-2983. If you have questions, please call our eClaims Service Line at 1-877-526-8390 or send an e-mail to edidirectsubmission@carefirst.com.

Site Information

Site/Practice Name* ____________________

Site Address* ____________________

Site Address Line 2 ____________________

Site City* ____________________

Site State* ____________________

Site Zip* ____________________

Contact Name (First, Last)* ____________________

Contact Phone* ____________________

Contact Fax ____________________

Contact Email* ____________________

Line of Business*

Please check all that apply. You must check at least one box.

CareFirst MD Professional (1500 Form)	☐
CareFirst MD Institutional (UB92 Form)	☐
CareFirst DC Professional (1500 Form)	☐
CareFirst DC Institutional (UB92 Form)	☐

Provider Information

You must fill these fields out to use the product.

If more than 5 providers are in your practice, please attach a spreadsheet listing the additional providers and their individual provider numbers.

DC Provider Number Format

Valid Group # = 4-digit (can be all-numeric or alpha-numeric (e.g., J230, 8364)

Valid Individual # = 4-digit all-numeric (e.g., 0001, 0002, etc.)

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MD Provider Number Format
Valid Group # = 5 or 6 character alpha-numeric (i.e., 4563P or H563PA)
Valid Individual # = 6 or 8 digit all-numeric

Group Tax ID* ______________________
DC Group Number* ______________________
MD Group Number* ______________________

Billing NPI ______________________
Rendering NPI ______________________

Individual Provider Number/s*
First Provider Name ______________________
DC Individual Number ______________________
MD Individual Number ______________________

First Provider Name ______________________
DC Individual Number ______________________
MD Individual Number ______________________

First Provider Name ______________________
DC Individual Number ______________________
MD Individual Number ______________________

First Provider Name ______________________
DC Individual Number ______________________
MD Individual Number______________________

First Provider Name ______________________
DC Individual Number ______________________
MD Individual Number______________________

User Information

User One
Profile Name (First, Last)* ______________________
Profile Email Address* ______________________
Profile Phone Number* ______________________

User Two
Profile Name (First, Last) ______________________
Profile Email Address ______________________
Profile Phone Number ______________________

****** required fields***

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