Electronic Claim Submission Enrollment Form

Practice Name: _____

Practice Tax ID #: _____

Contact Person: _____

Phone Number: _____

Email Address: _____

Clearinghouse Name: _____

Date of File Submission: _____

Claim Type: __ UB04 __ HCFA1500

Fax to: (850)383-3310

Attention: Network Services

Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association