



### PROVIDER LOGIN ASSIGNMENT

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#### Provider/Facility Information

Provider FName & LName/Facility Name

National Provider identifier (NPI)

Provider License/Tax ID

PCP

Specialist

User Email

Hospital/Ancillary

IPA/Medical Group

Organization URL

Clinic Email

Do you authorize Blue Shield Promise to display email address?

Yes  
No

Yes

No

#### Provider Site/Facility Information

Street Address

Phone Number

City, State, Zip

Fax number

Authorized Staff/Provider Name (Print)

Title

Signature

#### Blue Shield Promise Use Only

Username	Password
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