

Provider Information Change Form



An Independent Licensee of the Blue Cross Blue Shield Association

Use this form to update demographic information, such as addresses, tax ID, phone numbers, etc. Questions or changes related to contracts and networks should be directed to your assigned [provider liaison](#).

Please note: Chiropractors must make changes through American Specialty Health (ASH) at 1-800-972-4226.

Requested changes apply to the following provider: (Required information)

Provider Name		Degree (if applicable)
NPI Number	Tax ID Number	
Required for individual providers only. Check all that apply: <input type="checkbox"/> PCP (actively practicing as a PCP) <input type="checkbox"/> Office Based <input type="checkbox"/> Hospital Based		
Group Name (if applicable)		Group/Organization NPI Number

INSTRUCTIONS

- For tax ID changes, complete sections 3 through 12 to update or verify information.
- For all other changes, complete only the applicable sections.

1. Provider Name Change

Name	Degree (if applicable)
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2. Group/Organization NPI Number Change

Old Organizational NPI	New Organizational NPI	Effective date (mm/dd/yyyy) / /
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3. Tax ID Changes Add Tax ID Terminate Tax ID

Required: For all tax ID changes, complete sections 3 - 12 of this form to update or verify information.

Add Tax ID Number	Date provider started billing with this tax ID (mm/dd/yyyy) / /
Group Name	Group NPI Number
Terminate Tax ID Number	Last service date using this tax ID (mm/dd/yyyy) / /
Reason for change:	

4. ARE YOU ACCEPTING NEW PATIENTS? Yes No

5. Specialty - What specialty are you **actively** practicing?

Primary	Board Certified <input type="checkbox"/> Yes <input type="checkbox"/> No
Secondary	Board Certified <input type="checkbox"/> Yes <input type="checkbox"/> No
Check all that apply: <input type="checkbox"/> PCP (actively practicing as a PCP) <input type="checkbox"/> Office Based <input type="checkbox"/> Hospital Based	

6. Business Email – Not a personal email address

Business Email

7. Business Website URL

Website

Important information about addresses:

- BCBSAZ sends claim payments to the provider’s billing address. Unless a separate mailing address has been specified, other correspondence (including contract updates) is also sent to the billing address. An exception is medical records requests, which are sent to the primary location address if a separate medical records address is not specified.
- To update addresses, a signed notification from the provider (such as this form) is required and 60 days advance notice is requested to avoid delays. Please also inform the post office of any address changes that require temporary mail forwarding.
- For professional providers, the primary address must be a physical location in Arizona, where services are performed.
- For Facilities/Ancillary providers, you must complete a new [contract application-information form](#) to change your primary or additional address.

8. Primary Address/Phone/Office Hours – Physical location where services are performed.							
Street Address						Suite	
City						State	Zip
Phone			Fax			Effective Date (mm/dd/yyyy) / /	
Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time							
End Time							

9. Billing Address – Contracted provider payments will be sent to this address							
Street Address						Suite	
City						State	Zip
Phone			Fax			Effective Date (mm/dd/yyyy) / /	

10. Mailing Address – If no mailing address is specified, correspondence will be sent to the billing address							
Street Address						Suite	
City						State	Zip
Phone			Fax			Effective Date (mm/dd/yyyy) / /	

11. Medical Records – If different than primary address							
Street Address						Suite	
City						State	Zip
Phone			Fax			Effective Date (mm/dd/yyyy) / /	

12. Additional Office(s) – Add this address Correct this address Remove this address
 For individual providers, add only locations where the provider is actively practicing on a regular basis (use an attached sheet if necessary). Do not include locations where the provider works occasionally or covers for other providers.

Street Address		Suite	
City		State	Zip
Phone	Fax	Effective Date (mm/dd/yyyy) / /	

Office Hours for Additional Office(s)

Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time							
End Time							

13. Privileges (Hospital / Surgical Facilities) – If necessary, use an attached sheet to indicate more privileges changes.

Add this privilege Remove this privilege

Facility Name Active Courtesy Provisional

Additional information and comments:

Authorized [Electronic] Signature

I am _____, and I verify that I am authorized to submit this change form on behalf of the provider named above. I agree that by entering my name in the electronic signature field below, I am authorizing the changes indicated in this form.

/s/ _____ Date _____

Authorized [Electronic] Signature

SAVE, attach and email to: ProvNet@azblue.com or fax to: BCBSAZ Provider Partnerships 602-864-3142
Questions? Call 602-864-4231