

NON-CONTRACTED PROVIDER INFORMATION FORM



An Independent Licensee of the Blue Cross Blue Shield Association

Request to add or update non-contracted provider information for BCBSAZ claims

Use this form to add or update provider demographic information for out-of-network claim processing.

Note: BCBSAZ sends most out-of-network payments to the member.

CONTACT PERSON <i>(Required)</i>	Name of contact person for questions related to this request		
	Contact information	<input type="checkbox"/> Phone	<input type="checkbox"/> Email <i>(Required)</i>

Type of provider:

- 1. Individual provider (complete sections 1 and 3 below)
- 2. Facility (complete sections 2 and 3 below)

SECTION 1 – FOR INDIVIDUAL PROVIDERS ONLY						
INDIVIDUAL PROVIDER INFORMATION <i>(Required)</i>	Last Name		First Name		MI	Degree
	Gender	Date of Birth	Social Security Number	Individual NPI Number	Effective Date (mm/dd/yyyy)	
	<input type="checkbox"/> Male <input type="checkbox"/> Female				/ /	
	Group Name		DBA Name (if applicable)	Organization NPI Number	Effective Date (mm/dd/yyyy)	
				/ /		
	License Number	Effective Date (mm/dd/yyyy)	Primary Specialty (as listed on license)	Secondary Specialty (if applicable)		
		/ /				

SECTION 2 – FOR FACILITIES ONLY		
FACILITY INFORMATION <i>(Required)</i>	Legal Name - as on file with the AZ Corporation Commission	DBA (Doing Business As) Name – if applicable
	Facility NPI (indicate the NPI used for the primary service location)	Effective Date (mm/dd/yyyy)
	AZ License Number (include a copy of the license with this form)	Effective Date (mm/dd/yyyy)
	License Type and Specialty (or services provided)	
NOTE	If you are a post-acute care or behavioral health inpatient facility provider, we will send you an Inpatient Facility Questionnaire/Attestation to complete after we receive this form.	

Send with this form:
A copy of the facility's
ADHS (Arizona
Department of Health
Services) license

SECTION 3 – FOR ALL PROVIDERS

TAX ID and START DATE <i>(Required)</i>	Tax ID Number		Start Date (when provider started billing with this tax ID)	
			/ /	
PRIMARY ADDRESS Physical location where services are performed <i>(Required)</i>	Street Address			Suite
	City		State	Zip
	Phone		Fax	
BILLING ADDRESS (If different than primary address) <i>(Required)</i>	Same as primary address: <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Street Address			Suite
	City		State	Zip
	Phone		Fax	
MAILING ADDRESS (If no mailing address is specified, correspondence will be sent to the billing address)	Same as billing address: <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Street Address			Suite
	City		State	Zip
	Phone		Fax	
MEDICAL RECORDS (If different than primary address)	Same as primary address: <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Street Address			Suite
	City		State	Zip
	Phone		Fax	
Additional information/comments				

Authorized [Electronic] Signature *(Required)*

I am _____, and I verify that I am authorized to submit this request 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 request as indicated in this form.

/s/ _____ Date _____
Authorized [Electronic] Signature

Sign, save, and email this form to ProvNet@azblue.com (be sure to attach required documentation)
or fax to BCBSAZ Provider Partnerships at 602-864-3142
Questions? Call 602-864-4231 or 1-800-232-2345 ext. 4231