

Blue Cross Blue Shield of Arizona Provider Change Form



NOTE: If BCBSAZ does not receive a new address from the provider in writing, BCBSAZ will continue sending correspondence, including claims payments, to the address currently listed in BCBSAZ's system. BCBSAZ will not be responsible for lost or returned mail if we do not receive this form from the provider sixty (60) days prior to the effective date of the change. In addition, we recommend that the provider submit a change of address form through the post office.

(Please complete the applicable information.)

Address Change
 Tax ID Change
 NPI
 Name Change
 Misc Change

PROVIDER NAME and DEGREE:	(Last)	(First)	(MI)	Degree (MD, DO, etc.):
	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: / / (mm/dd/yyyy)	SSN:	
NAME CHANGE?	(Last)	(First)	(MI)	Degree (MD, DO, etc.):
NPI: Please provide a copy of your confirmation from NPPES	Individual NPI: _____ Effective Date: ____/____/____ If New, reason: _____ Organization NPI (if applicable) : _____ Effective Date: ____/____/____ Org Name: _____			
TAXONOMY:	Individual Taxonomy: _____ Organization Taxonomy: _____ (If applicable)			
What Specialty are you actively practicing? Primary: _____ Board Certified <input type="checkbox"/> Y <input type="checkbox"/> N Secondary: _____ Board Certified <input type="checkbox"/> Y <input type="checkbox"/> N				
AZ License No: _____ Issued Effective Date: ____/____/____				
TAX ID: (Effective and termination dates required for processing)	Existing Tax ID #: ____-____-____-____-____ <input type="checkbox"/> Add New Tax ID #: ____-____-____-____-____ Effective Date: ____/____/____ <input type="checkbox"/> Terminate Tax ID #: ____-____-____-____-____ Term Date: ____/____/____ Termination Reason: _____			
PROVIDER DIRECTORY: Include <input type="checkbox"/> Exclude <input type="checkbox"/>			PATIENT CAPACITY: _____ (Tricare Primary Care Managers Only)	
MEDICARE PROVIDER BILLING NUMBER: _____ Part A <input type="checkbox"/> Part B <input type="checkbox"/> Effective Date: ____/____/____				
UPIN: _____ Effective Date: ____/____/____			DEA# _____	
(If applicable) GROUP PRACTICE NAME (DBA): _____				
BILLING SERVICE (If applicable): Name: _____ Address: _____ Suite # _____ City: _____ State: _____ Zip: _____ Phone: () _____ Fax: () _____				

New Delete Effective Date ____/____/____

PRIMARY ADDRESS: (Physical location where services are performed)	Street: _____ Suite # _____
	City: _____ State: _____ Zip: _____
	E-Mail Address: _____
	Phone: () _____ Fax: () _____ Office Hours: _____

Add Delete Effective Date ____/____/____

MAILING ADDRESS: (All correspondence will be sent to this address)	Street: _____ Suite # _____
	City: _____ State: _____ Zip: _____
	Phone: () _____ Fax: () _____

Add Delete Effective Date ____/____/____

BILLING ADDRESS: (Contracted provider payments will be sent to this address)	Street: _____ Suite # _____
	City: _____ State: _____ Zip: _____
	Phone: () _____ Fax () _____

Add Delete Effective Date ____/____/____

ADDITIONAL OFFICE (if applicable)	Street: _____ Suite # _____
	City: _____ State: _____ Zip: _____
	Office Hours: _____
	Phone: () _____ Fax: () _____ Office Hours _____

HOSPITAL /FREE STANDING SURGERY FACILITIES PRIVILEGES:

(Indicate other additional privileges on an attached sheet)

_____	<input type="checkbox"/> ACTIVE <input type="checkbox"/> COURTESY <input type="checkbox"/> DELIVERY <input type="checkbox"/> PROVISIONAL
_____	<input type="checkbox"/> ACTIVE <input type="checkbox"/> COURTESY <input type="checkbox"/> DELIVERY <input type="checkbox"/> PROVISIONAL
_____	<input type="checkbox"/> ACTIVE <input type="checkbox"/> COURTESY <input type="checkbox"/> DELIVERY <input type="checkbox"/> PROVISIONAL

ASC PRIVILEGES: _____

Please allow approximately 5 to 10 business days for the processing of your request.

FAX TO: BCBSAZ Network Management (602) 864-3142 Questions: (602) 864-4231

Submitter's Name: _____ **Date:** ____/____/____