

# 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**

<b>PROVIDER NAME and DEGREE:</b>				
	(Last)	(First)	(MI)	Degree (MD, DO, etc.):
	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: / / (mm/dd/yyyy)	SSN:	
<b>Business Email:</b> (Not personal Email)	NOTE: Contracts will be sent to Business Email provided Email: _____			
<b>BUSINESS Website :</b>	Website: _____			
<b>NAME CHANGE?</b>				
	(Last)	(First)	(MI)	Degree (MD, DO, etc.):
<b>GROUP PRACTICE NAME:</b>	Doing Business as: _____			
<b>NPI:</b>	Individual NPI: _____ Effective Date: ___/___/___ If New, reason: _____ Organization NPI (if applicable) : _____ Effective Date: ___/___/___ Org Name: _____			
<b>What Specialty are you actively practicing?</b>				
Primary: _____ Board Certified <input type="checkbox"/> Y <input type="checkbox"/> N				
Secondary: _____ Board Certified <input type="checkbox"/> Y <input type="checkbox"/> N				
Individual Taxonomy: _____				
AZ License No: _____ Issued Effective Date: ___/___/___				
<b>TAX ID:</b> (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: _____			
<b>PROVIDER DIRECTORY:</b> Include <input type="checkbox"/> Exclude <input type="checkbox"/>			<b>PATIENT CAPACITY:</b> _____ (Tricare Primary Care Managers Only)	
<input type="checkbox"/> Add <input type="checkbox"/> Delete Effective Date ___/___/___				
<b>BILLING SERVICE</b> (If applicable):				
Name: _____				
Address: _____ Suite # _____				
City: _____ State: _____ Zip: _____				
Phone: ( ) _____ Fax: ( ) _____				

Add  Delete Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>PRIMARY ADDRESS:</b> (Physical location where services are performed)	Street: _____ Suite # _____
	City: _____ State: _____ Zip: _____
	Business E-Mail: _____
	Phone: ( ) _____ Fax: ( ) _____ Office Hours: _____
	Authorization/Referral Fax: ( ) _____

Add  Delete Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Add  Delete Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Add  Delete Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>MEDICAL RECORDS:</b> (If different than primary location)	Street: _____ Suite: _____
	City: _____ State: _____ Zip: _____
	Phone: ( ) _____ Fax: ( ) _____

Add  Delete Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>ADDITIONAL OFFICE</b> (Indicate other additional offices on an attached sheet, if necessary)	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)

\_\_\_\_\_ ACTIVE COURTESY DELIVERY PROVISIONAL  
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\_\_\_\_\_ ACTIVE COURTESY DELIVERY PROVISIONAL

**ASC PRIVILEGES:** \_\_\_\_\_

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

**Submitter's Name:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_