



Blue Cross Blue Shield of Arizona Non-Contracted Provider Request

NOTE: This is a request to add or update provider demographics in the claims adjudication system for processing purposes.
For non-contracted providers, BCBSAZ remits most payments to the member.

Please complete the following information.

PROVIDER:	Name: _____		
	(Last)	(First)	(Middle)
	Degree (MD, DO, etc.): _____	Gender M / F _____ Birthdate: / / _____	SSN #: _____
PRACTICING SPECIALTIES:			
Are you practicing as a PCP or Specialist? <input type="checkbox"/> PCP <input type="checkbox"/> Specialist			
Primary: _____			
Secondary: _____			
Individual Taxonomy: _____			
NPI:	Individual NPI: _____ Effective date: ____/____/____		
	If New, reason: _____		
	Organization NP(if applicable): _____ Effective date: ____/____/____		
	Org Name: _____		
TAX ID:	Tax ID #: _____ Date provider started billing w/tax ID: ____/____/____ (Required for processing)		
LICENSE:	Date first licensed to practice medicine (other than AZ): Yr: _____ State: _____		
	AZ License #: _____ Date First Issued: ____/____/____		
SECONDARY ID'S:	Medicare ID: _____ A <input type="checkbox"/> B <input type="checkbox"/> Issued Effective. date: ____/____/____		
	DEA # _____ Issued Effective date: ____/____/____		
OFFICE CONTACT:	Name: _____		
	Phone: () _____ Fax: () _____		
PRIMARY ADDRESS: (Physical location where services are performed)	Street: _____ Suite _____		
	City: _____ State: _____ Zip: _____		
	Phone: () _____ Fax: () _____ Authorization Fax: () _____		
MAILING ADDRESS: (All correspondence will be sent to this address)	Street: _____ Suite _____		
	City: _____ State: _____ Zip: _____		
	Phone: () _____ Fax () _____		
BILLING ADDRESS: (If different than primary)	Name: _____		
	Address: _____ Suite # _____		
	City: _____ State: _____ Zip: _____		
	Phone: () _____ Fax: () _____		
PLEASE ATTACH A SEPARATE SHEET FOR ADDITIONAL ADDRESSES.			

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

Signature _____ Date ____/____/____