

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: _____ Board Certified <input type="checkbox"/> Y <input type="checkbox"/> N			
Secondary: _____ Board Certified <input type="checkbox"/> Y <input type="checkbox"/> N			
NPI:	Individual NPI: _____ Effective date: ____/____/____		
PLEASE SUBMIT A COPY OF YOUR NPI CONFIRMATION FROM NPDES	If New, reason: _____		
	Organization NP(if applicable): _____ Effective date: ____/____/____		
	Org Name: _____		
TAXONOMY:	Individual Taxonomy: _____ Organization Taxonomy: _____		
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: ____/____/____		
	UPIN: _____ Issued Effective date: ____/____/____		
	DEA # _____ Issued Effective date: ____/____/____		
OFFICE CONTACT:	Name: _____ Office E-Mail: _____		
	Phone: () _____ Fax: () _____		
PRIMARY ADDRESS: (Attach a separate sheet for additional office locations)	Street: _____ Suite _____		
	City: _____ State: _____ Zip: _____		
	Phone: () _____ Fax: () _____ Office Hours: _____		
MAILING ADDRESS: (All correspondence will be sent to this address)	Street: _____ Suite _____		
	City: _____ State: _____ Zip: _____		
	Phone: () _____ Fax () _____		
BILLING SERVICE (If applicable):	Name: _____		
	Address: _____ Suite # _____		
	City: _____ State: _____ Zip: _____		
	Phone: () _____ Fax: () _____		

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

Signature _____

Date ____/____/____