

# Facility Provider File Update Form



Today's Date: \_\_\_\_\_ Effective Date of Change \_\_\_\_\_

Type of Facility:

- Hospital
- Ambulatory Surgery Center
- Home Health
- Hospice
- Skilled Nursing
- Rural Health Clinic
- Dialysis Center

National Provider Identification (NPI): \_\_\_\_\_

Federal Tax ID Number: \_\_\_\_\_

Physical Address \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State ZIP Code

Phone No. \_\_\_\_\_

Fax No. \_\_\_\_\_

**If you would like correspondence or checks and remittance advices mailed to a different address, please indicate below.**

Correspondence \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State ZIP Code

Checks/Remittance Advice \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State ZIP Code

CEO/Administrator Name: \_\_\_\_\_ Title: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

CFO/Business Office Manager Name: \_\_\_\_\_ Title: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Name of person completing this form: \_\_\_\_\_ Title: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Attn: Institutional Relations, cc 445D2  
Blue Cross and Blue Shield of Kansas  
PO Box 239  
Topeka, KS 66629  
Fax: (785) 290-0734

**Your signature required**

**Date** \_\_\_\_\_