

Provider Information Change Form

If you relocate or change any of the following information or as providers move within or leave your practice please use this form to notify us.

Section 1

Provider/Group Name _____

Provider Billing NPI Number* _____ SSN or Tax ID Number* _____

*Use a separate change form for each Billing NPI Number and/or Tax ID Number applicable to your request.

Please make the following change(s) to my provider record:

- New Address (complete Section 2)
- Group or Provider Name Change (complete Section 3)
- Additional Address (complete Section 4)
- Termination Request (complete Section 5)

_____/_____/_____
Effective Date

Section 2

Old location address:

Street Address _____

City _____

State _____ ZIP Code _____ +4 _____

(_____) _____ - _____
Location Phone Number Location Fax Number

Old mailing/correspondence address:

Street Address _____

City _____

State _____ ZIP Code _____ +4 _____

(_____) _____ - _____
Mailing Phone Number Mailing Fax Number

Old billing/payment/remittance address:

Street Address _____

City _____

State _____ ZIP Code _____ +4 _____

(_____) _____ - _____
Billing Phone Number Billing Fax Number

New location address:

Street Address _____

City _____

State _____ ZIP Code _____ +4 _____ Office Hours _____

(_____) _____ - _____
Location Phone Number Location Fax Number

New mailing/correspondence address:

Street Address _____

City _____

State _____ ZIP Code _____ +4 _____

(_____) _____ - _____
Mailing Phone Number Mailing Fax Number

New billing/payment/remittance address:

Street Address _____

City _____

State _____ ZIP Code _____ +4 _____

(_____) _____ - _____
Billing Phone Number Billing Fax Number

Section 3

Group or provider name change (not involving a Tax ID# or NPI# change):

Current Group Legal Name _____

New Group Legal Name _____

Current Directory Group Name _____

New Directory Group Name _____

Provider Name _____

Provider NPI Number _____

New Provider Name _____

Please continue on the next page.

Section 4

Additional location address:

Street Address

City

State ZIP Code +4 Office Hours

() -
Location Phone Number

() -
Location Fax Number

Additional mailing/correspondence address:

Street Address

City

State ZIP Code +4

() -
Mailing Phone Number

() -
Mailing Fax Number

Additional billing/payment/remittance address:

Street Address

City

State ZIP Code +4

() -
Billing Phone Number

() -
Billing Fax Number

Please list the providers who will be practicing at this additional location address (submit attachment if needed):

Provider Name Provider NPI Number

Provider Name Provider NPI Number

Provider Name Provider NPI Number

Provider Name Provider NPI Number

Section 5

Terminate solo provider:

Provider Name

Provider NPI Number

Term Date / /

Reason for termination

Terminate provider(s) from the group at *all* locations:

Provider Name

Provider NPI Number

Term Date / /

Reason for termination

Provider Name

Provider NPI Number

Term Date / /

Reason for termination

Terminate provider(s) at the *following locations only*:

Provider Name

Provider NPI Number

Term Date / /

Reason for termination

Practice location addresses applicable to this provider's term request

Provider Name

Provider NPI Number

Term Date / /

Reason for termination

Practice location addresses applicable to this provider's term request

Terminate the entire group, to include *all locations* and *all professionals* tied to it

Your signature required

Authorizing Signature

Date Signed / /

Completed by (please print)

() -
Contact Phone Number

() -
Contact Fax Number

Please send completed form to the e-mail address, fax number or mailing address below:

Email: ProviderNetworkEnrollment@bcbsks.com

Fax: (785) 290-0734

Provider Network Services – CC443D2

P.O. Box 239, Topeka, KS 66601

Phone: In Topeka, call (785) 291-4135, opt. 3; or outside Topeka, call toll free 1-800-432-3587