Provider Information Change Form

BlueCross BlueShield Kansas

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

New location address:

Street Address

City

State ZIP Code +4 Office Hours

(______) ______-_________
Location Phone Number

(______) ______-_________
Location Fax Number

Old mailing/correspondence address:

Street Address

City

State ZIP Code +4

(______) ______-_________
Mailing Phone Number

(______) ______-_________
Mailing Fax Number

New 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 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.

An independent licensee of the Blue Cross Blue Shield Association.

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: prof.relations@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