

Blue Cross Blue Shield of Arizona Provider Change Form



NOTE: If BCBSAZ does not receive a new address from the provider in writing, BCBSAZ will continue sending correspondence, including claims payments, to the address currently listed in BCBSAZ's system. BCBSAZ will not be responsible for lost or returned mail if we do not receive this form from the provider sixty (60) days prior to the effective date of the change. In addition, we recommend that the provider submit a change of address form through the post office.

(Please complete the applicable information.)

Address Change
 Tax ID Change
 NPI
 Name Change
 Misc Change

PROVIDER NAME and DEGREE:				
	(Last)	(First)	(MI)	Degree (MD, DO, etc.):
	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: / / (mm/dd/yyyy)	SSN:	
BUSINESS WEBSITE	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete:			
NAME CHANGE?				
	(Last)	(First)	(MI)	Degree (MD, DO, etc.):
NPI: Please provide a copy of your confirmation from NPES	Individual NPI: _____ Effective Date: ___ / ___ / ___ If New, reason: _____			
	Organization NPI (if applicable) : _____ Effective Date: ___ / ___ / ___ Org Name: _____			
TAXONOMY:	Individual Taxonomy: _____ Organization Taxonomy: _____ (If applicable)			
What Specialty are you actively practicing?				
Primary: _____ Board Certified <input type="checkbox"/> Y <input type="checkbox"/> N				
Secondary: _____ Board Certified <input type="checkbox"/> Y <input type="checkbox"/> N				
AZ License No: _____ Issued Effective Date: ___ / ___ / ___				
TAX ID: (Effective and termination dates required for processing)	Existing Tax ID #: _____ <input type="checkbox"/> Add New Tax ID #: _____ Effective Date: ___ / ___ / ___ <input type="checkbox"/> Terminate Tax ID #: _____ Term Date: ___ / ___ / ___ Termination Reason _____			
PROVIDER DIRECTORY: Include <input type="checkbox"/> Exclude <input type="checkbox"/>		PATIENT CAPACITY: _____ (Tricare Primary Care Managers Only)		
MEDICARE PROVIDER BILLING NUMBER: _____ Part A <input type="checkbox"/> Part B <input type="checkbox"/> Effective Date: ___ / ___ / ___				
UPIN: _____ Effective Date: ___ / ___ / ___			DEA# _____	
(If applicable) GROUP PRACTICE NAME (DBA): _____				
BILLING SERVICE (If applicable): Name: _____				
Address: _____ Suite # _____				
City: _____ State: _____ Zip: _____				
Phone: () _____ Fax: () _____				

New Delete Effective Date ____/____/____

PRIMARY ADDRESS: (Physical location where services are performed)	Street: _____ Suite # _____
	City: _____ State: _____ Zip: _____
	E-Mail Address: _____
	Phone: () _____ Fax: () _____ Office Hours: _____

Add Delete Effective Date ____/____/____

MAILING ADDRESS: (All correspondence will be sent to this address)	Street: _____ Suite # _____
	City: _____ State: _____ Zip: _____
	Phone: () _____ Fax: () _____

Add Delete Effective Date ____/____/____

BILLING ADDRESS: (Contracted provider payments will be sent to this address)	Street: _____ Suite # _____
	City: _____ State: _____ Zip: _____
	Phone: () _____ Fax () _____

Add Delete Effective Date ____/____/____

ADDITIONAL OFFICE (if applicable)	Street: _____ Suite # _____
	City: _____ State: _____ Zip: _____
	Office Hours: _____
	Phone: () _____ Fax: () _____ Office Hours _____

HOSPITAL /FREE STANDING SURGERY FACILITIES PRIVILEGES:
(Indicate other additional privileges on an attached sheet)

PROVISIONAL	<input type="checkbox"/> ACTIVE <input type="checkbox"/> COURTESY <input type="checkbox"/> DELIVERY <input type="checkbox"/>
PROVISIONAL	<input type="checkbox"/> ACTIVE <input type="checkbox"/> COURTESY <input type="checkbox"/> DELIVERY <input type="checkbox"/>
PROVISIONAL	<input type="checkbox"/> ACTIVE <input type="checkbox"/> COURTESY <input type="checkbox"/> DELIVERY <input type="checkbox"/>
ASC PRIVILEGES: _____	

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

Submitter's Name: _____ **Date:** ____/____/____