PROVIDER DEMOGRAPHIC CHANGE FORM

BlueCross BlueShield of Western New York
PROVIDER ENROLLMENT DEPARTMENT
257 West Genesee Street • Buffalo, NY 14202

"CONFIDENTIAL"

Please complete all sections of this form; reply N.A. if not applicable.

For questions or assistance, please call (716) 887-2054 Fax completed form to 716-887-8886

Section I: Demographic Data

Name: Last First MI

______________________ ____________________ ____

Group/Facility Name:
____

NPI # ______________________________

CAQH # ______________________________

MEDICARE # ______________________

Primary Hospital Affiliation & Status: ____________________

Title: ❐ MD ❐ DO ❐ DMD ❐ DDS ❐ DPM ❐ PT ❐ OT ❐ ST ❐ OD ❐ AUD ❐ NP* ❐ PA** ❐ CNM* ❐ CRNA** ❐ Other: ____

* Agreement/Acknowledgement Form required for NP/CNM and collaborating/supervising Physician.

** Supervision Data Form required for PA/CRNA's

____

Ethnic Info (optional): Please fill out the section below. This information will assist in the referral process, as members often request providers with a specific ethnic background. The information will not affect your provider status.

American Indian or Alaska Native ___ African-American ___

Asian or Pacific Islander ___ Caucasian ___ Hispanic ___

Section II: Data Change Summary

THE PURPOSE OF THIS NOTICE IS: (please check appropriate boxes below)

❐ Adding location Effective Date _____________ Tax ID: _______________________

Primary Specialty at Site _____________ Secondary Specialty at Site _____________

Accepting New Patients? ____________

Can patients schedule an appointment to be seen by this Practitioner at this site? _____________

Are Services Inpatient Only? ___________ Is this site a Nursing Home? _____________

Restrictions in Practice (ex: age, covering only, diagnostic services only): ____________________

❐ Terming Location Effective Date ____________ Which site: _______________________ Tax ID: ______________________

Reason: ___________________________

❐ Address Change Only Effective Date ____________ Tax ID: _______________________

Applies to: Physical Address _____ Remit Address ____ Correspondence Address _____

❐ Tax ID Change: Effective Date ____________ New Tax ID _______________________ Old Tax ID _______________________

Is Tax ID Change related to a change in ownership? YES __________ NO ______________

For tax changes related to changes in ownership, a completed copy of the Disclosure of Ownership and Control form must be submitted.

❐ PCMH Update Group Name ______________________ ❐ Recognition status change ❐ New recognition notice

Patient Centered Medical Home – Recognition e-mail received from NCQA is required; Including Recognition Level, Locations, Effective Date/Term Date and Listing of Providers (Name, NPI).

❐ Other (please specify): Effective Date ____________ Change ____

Section III: Data Change Detail - Please include ONLY the location or information you are updating. Use a separate sheet if necessary for multiple changes.

If the same change applies to multiple providers in your group, complete the update below and attach a listing of providers for which the change applies.

NEW INFORMATION				OLD INFORMATION			
Physical Street Address				Physical Street Address			
City	State	County	Zip	City	State	County	Zip
Phone: Fax: Email:				Phone: Fax: Email:			
Handicapped Accessible ❐ Yes ❐ No * (if No, see Sec IV)	Tax ID No:			Handicapped Accessible ❐ Yes ❐ No	Tax ID No:		

Doctors Hours (exact times)	Doctors Hours (exact times)
AM- Mon__-__Tue __-__Wed __-__Thur __-__Fri __-__ Sat __-__ Sun __-__	AM Mon__-__Tue __-__Wed __-__Thur __-__Fri __-__ Sat __-__ Sun __-__
PM- Mon__-__Tue __-__Wed __-__Thur __-__Fri __-__ Sat __-__ Sun __-__	PM Mon__-__Tue __-__Wed __-__Thur __-__Fri __-__ Sat __-__ Sun __-__
Office Hours (exact times)	Office Hours (exact times)
AM- Mon__-__Tue __-__Wed __-__Thur __-__Fri __-__ Sat __-__ Sun __-__	AM- Mon__-__Tue __-__Wed __-__Thur __-__Fri __-__ Sat __-__ Sun __-__
PM- Mon__-__Tue __-__Wed __-__Thur __-__Fri __-__ Sat __-__ Sun __-__	PM- Mon__-__Tue __-__Wed __-__Thur __-__Fri __-__ Sat __-__ Sun __-__
Languages spoken (by provider in this office):	Languages spoken (by provider in this office):
Payment Name and Address if different from above, complete next section:	**Payment Name and Address if different from above, complete next section:**
Pay To Street Address:	Pay To Street Address:
City: State: Zip:	City: State: Zip:
Billing Service Name: Phone: Fax: Email:	Billing Service Name: Phone: Fax: Email:
Provider Group/Facility Name:______________________________________ **Group/Facility NPI#:** ______________________________________ **Facility Operating Certificate:** ___________________________________ **Permanent Facility Number:** ____________________________________	**Provider Group/Facility Name:**______________________________________ **Group/Facility NPI#:** ______________________________________ **Facility Operating Certificate:** ___________________________________ **Permanent Facility Number:** ____________________________________
Street Address:	Street Address:
City: State: Zip:	City: State: Zip:
Contact Name: Contact Phone: Email Address:	Contact Name: Contact Phone: Email Address:
Correspondence to: Service Site Group Address Remit Address Other ____	Correspondence to: Service Site Group Address Remit Address Other ____

Section IV: Wheelchair Accessibility: (If office is not wheelchair accessible, please indicate how wheelchair dependent patients are accommodated)

- ❒ Refer to local hospital
- ❒ Service at member residence
- ❒ Refer to local clinic
- ❒ Service member at facility
- ❒ Refer to other office or location

Section V: On-Call Physician Coverage -(complete if you are a solo practitioner, or if you are in a group practice and have coverage outside of your group)

Must be participating with BlueCross BlueShield of Western New York. In the last column, please indicate if you are on-call for each physician you list as on-call for you. On-call coverage _must_ be in the same or similar specialty.

Name	Specialty	Phone	On-call
Name	Specialty	Phone	On-call
Name	Specialty	Phone	On-call

Name of person completing this form: ____

Contact method for questions regarding this form (phone number or email address): _____________________________

Signature of person completing this form: ____ **Date:** ___________________