Independence Blue Cross

Provider Change Form

Reference:
Date received: _____

CURRENT PRACTICE INFORMATION

This change affects: ❑ Group practice ❑ Individual physician

(Group practice) or (Individual physician) name _____

NPI: ☐☐☐☐☐☐☐☐☐☐ NPI effective date: ____ / ____ /____

(Group practice) or (Individual physician) Provider Number:

HMO ID #: ☐☐☐☐☐☐☐☐☐☐

PPO ID #: ☐☐☐☐☐☐☐☐☐☐

PHONE #: ☐☐☐☐☐☐☐☐☐☐

Contact person _____

(Change will not be completed without signature)

Authorizing signature: _____

(Physician/office manager signature required)

Effective date of change: ____ / ____ /____

Today's date: ____ / ____ /____

PROVIDER CHANGE INFORMATION

PROVIDE COMPLETE INFORMATION – Your request will be processed for the HMO & PPO line of business. **Changes will be effective within 30 days**. If any of these changes result in a change on your W-9, you must submit a copy of your W-9 Form with this change form.

Type of change: *(Check all that apply)*

❑ Adding a practice ❑ Adding an office location ❑ Telephone ❑ Name change only

❑ Joining a practice ❑ Changing an office location ❑ Fax ❑ Tax ID change

PREVIOUS OFFICE INFORMATION

_____
Name

_____
Street address

_____
City State ZIP

____ - _____ ____ - _____
Telephone Fax

KHPE group practice provider: _____

PBS group practice provider: _____

NEW OFFICE INFORMATION

_____
Name

_____
Street address

_____
City State ZIP

____ - _____ ____ - _____
Telephone Fax

KHPE group practice provider: _____

PBS group practice provider: _____

Physician Members – Please check each as an Add or a Delete to your practice.

1. _____ _____
Last First Middle Degree

ADD DELETE
Individual provider ID#: ☐☐☐☐☐☐☐☐☐☐ ☐ ☐
NPI: ☐☐☐☐☐☐☐☐☐☐ NPI eff. date: ___ / ___ / ___
Taxonomy code: _____

2. _____ _____
Last First Middle Degree

ADD DELETE
Individual provider ID#: ☐☐☐☐☐☐☐☐☐☐ ☐ ☐
NPI: ☐☐☐☐☐☐☐☐☐☐ NPI eff. date: ___ / ___ / ___
Taxonomy code: _____

3. _____ _____
Last First Middle Degree

ADD DELETE
Individual provider ID#: ☐☐☐☐☐☐☐☐☐☐ ☐ ☐
NPI: ☐☐☐☐☐☐☐☐☐☐ NPI eff. date: ___ / ___ / ___
Taxonomy code: _____

4. _____ _____
Last First Middle Degree

ADD DELETE
Individual provider ID#: ☐☐☐☐☐☐☐☐☐☐ ☐ ☐
NPI: ☐☐☐☐☐☐☐☐☐☐ NPI eff. date: ___ / ___ / ___
Taxonomy code: _____

❑ **BILLING LOCATION**

_____
Street address 1

_____
Street Address 2

_____
City State ZIP

____ - _____ ____ - _____
Telephone Fax

_____
Federal tax ID #

❑ **CHANGE OF OWNERSHIP** (requires NPI certification form)

Legal business name of new owner: _____ _____ _____ _____
Last First Middle Degree

Projected effective date of change of ownership: _____ ___/____ ___/____

Tax ID number of potential new owner (r*equires a new W-9 Form*) _____

Please provide a brief explanation of change/request _____

Please mail or fax this change form and supporting document to: Network Administration; Independence Blue Cross; P.O. Box 41431; Philadelphia, PA 19101-1431; Fax 215-988-6080

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