

Provider Change Form

(*Denotes a required field/section)

1. Current practice information*			
Group practice name:			
Group practice NPI number:			
Street address 1:		Street address 2:	
City:	State:	ZIP:	Fax:
Contact person:		Authorizing signature: <i>(Physician/office manager signature required)</i>	
Phone #:		Phone #:	
Effective date of change:		Today's date:	
2. Provider change information*			
Provide complete information – Your request will be processed for all of your active lines of business. Changes will be effective within 30 business days. If any of these changes will 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):			
<input type="checkbox"/> Update current office information (Field 3): <input type="checkbox"/> Add/Delete an office location (Field 4) <input type="checkbox"/> New mailing address (Field 6)			
<input type="checkbox"/> Practice name <input type="checkbox"/> Phone number <input type="checkbox"/> Address <input type="checkbox"/> Fax number <input type="checkbox"/> Add/Delete a physician to/from existing group (Field 5) <input type="checkbox"/> New payment information (Field 7)			
3. Update current office information* <input type="checkbox"/> Keep current <input type="checkbox"/> Delete <input type="checkbox"/> Update (update relevant information below)			
Group practice name:			
Street address 1:		Street address 2:	
City:	State:	ZIP:	Fax:
Telephone:		Fax:	
4. Office locations – Please check each as an Add or a Delete to your practice. (see page 2, Field 9 to add additional office locations)			
1. Group practice name:		Group practice NPI #: <input type="checkbox"/> Add <input type="checkbox"/> Delete	
Street address 1:		Effective date:	
Street address 2:			
City:	State:	ZIP:	
Telephone:	Fax:		
5. Physicians – Please check each as an Add or a Delete to your practice. (see page 2, Field 10 to add additional physicians)			
1. Name (last, first, middle):		Individual provider NPI #: <input type="checkbox"/> Add <input type="checkbox"/> Delete	
Specialty:		Effective date:	
6. New mailing address (if different from your current practice information address in Field 1)			
Street Address 1:		Telephone:	Fax:
Street Address 2:		Federal tax ID #:	
City:	State:	Zip:	
7. New payment information (if different from your current practice information address in Field 1)			
Street Address 1:		Telephone:	Fax:
Street Address 2:		Federal tax ID #:	
City:	State:	ZIP:	

8. Current practice information* (Required if adding/deleting offices and/or physicians from page 1. Same as Field 1 on page 1.)				
Group practice name:				
Group practice NPI number:				
9. Additional office locations – Please check each as an Add or a Delete to your practice.†				
2. Group practice name:		Group practice NPI #: <input type="checkbox"/> Add <input type="checkbox"/> Delete		
Street address 1:		Effective date:		
Street address 2:				
City:	State:			ZIP:
Telephone:	Fax:			
3. Group practice name:				Group practice NPI #: <input type="checkbox"/> Add <input type="checkbox"/> Delete
Street address 1:		Effective date:		
Street address 2:				
City:	State:			ZIP:
Telephone:	Fax:			
10. Additional physicians – Please check each as an Add or a Delete to your practice.†				
2. Name (last, first, middle):		Individual provider NPI#: <input type="checkbox"/> Add <input type="checkbox"/> Delete		
Specialty:		Effective date:		
3. Name (last, first, middle):		Individual provider NPI#: <input type="checkbox"/> Add <input type="checkbox"/> Delete		
Specialty:		Effective date:		
4. Name (last, first, middle):		Individual provider NPI#: <input type="checkbox"/> Add <input type="checkbox"/> Delete		
Specialty:		Effective date:		
5. Name (last, first, middle):		Individual provider NPI#: <input type="checkbox"/> Add <input type="checkbox"/> Delete		
Specialty:		Effective date:		

*Denotes a required field/section.

†If there are additional office locations or physicians, feel free to copy the form to accommodate.

Independence Blue Cross (Independence) will not be responsible for changes not processed due to lack of proper notice from the Provider. Refer to “Resignation/termination from the Independence network” in the Administrative Procedures section of the *Provider Manual for Participating Professional Providers* for more information regarding the lead time requirements.

Please fax (preferred) or mail this change form and supporting documentation to:

Fax: (Preferred method of submission)
215-238-2275

Mail:
Independence Blue Cross
Attn: Network Administration
P.O. Box 41431
Philadelphia, PA 19101-1431