Independence

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 _____ Telephone ____-____ Fax ____-____

Street Address 2 _____ Federal tax ID# _____

City _____ State _____ ZIP _____

❑ **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 (*requires a new W-9 Form*): _____

Please provide a brief explanation of change/request: _____

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

Network Administration; Independence Blue Cross; P.O. Box 41431; Philadelphia, PA 19101-1431; Fax 215-238-2275

Independence Blue Cross is an independent licensee of the Blue Cross and Blue Shield Association.