BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

PROVIDER CHANGE NOTIFICATION FORM

Effective Date of Change

Month ☐☐ – *Date* ☐☐ – *Year* ☐☐☐☐

Accurate and complete information is important for providers and Blue Cross and Blue Shield of Alabama. Our provider file is utilized for remittance payments, Internal Revenue reporting, directories and publication mailings. To update your information in our provider records, complete this form, sign and mail or fax it to the address below.

Please note that changes to the Payee/Remittance Address and Tax Address require an authorized, original signature of the CEO, CFO, President, Tax Manager or Provider to sign section 3. If necessary, additional changes may be attached to this form after completing sections 1 and 3.

1. Current information

Provider Name	Individual NPI *(National Provider Identifier)* ☐☐☐☐☐☐☐☐☐☐
Practice Name	Tax ID Number ☐☐ – ☐☐☐☐☐☐☐

Current Address

City	State	Zip
Appointment Phone	Office Phone	Fax Number
Office E-mail	Provider E-mail	

☐ Changes to provider listed above only ☐ All providers at this address ☐ All providers in tax id

2. Please indicate any updates below.

New Office Address

City	State	Zip
Appointment Phone	Office Phone	Fax Number
Office E-mail	Provider E-mail	

Daily Office Hours	*SUNDAY*	*MONDAY*	*TUESDAY*	*WEDNESDAY*	*THURSDAY*	*FRIDAY*	*SATURDAY*
	☐AM ☐AM ___ ☐PM ___ ☐PM	☐AM ☐AM ___ ☐PM ___ ☐PM	☐AM ☐AM ___ ☐PM ___ ☐PM	☐AM ☐AM ___ ☐PM ___ ☐PM	☐AM ☐AM ___ ☐PM ___ ☐PM	☐AM ☐AM ___ ☐PM ___ ☐PM	☐AM ☐AM ___ ☐PM ___ ☐PM

*** New Payee/Remit Address** ☐ *(Same as above)*

City	State	Zip
Payee/Remit Phone	Fax Number	Payee NPI ☐☐☐☐☐☐☐☐☐☐

*** New Tax Address** ☐ *(Same as above)*

City	State	Zip

New Correspondence Address ☐ *(Same as above)*

City	State	Zip

Accepting new patients: ☐ Yes ☐ No ***If yes:*** ☐ Accepting all *(or check all that apply)* ☐ Blue Cross ☐ Blue Advantage ☐ Medicare ☐ Medicaid

3. Requires authorized, original signature of the CEO, CFO, President, Tax Manager or Provider.

I certify this information is complete and correct to the best of my knowledge.

Signature *(Required)* _____ Title *(Required)* _____ Date _____

Submission Instructions

FAX: Fax the signed and completed form to Attn: Credentialing **1-205-220-9545**

MAIL: **Blue Cross and Blue Shield of Alabama,** Attn: Credentialing Post Office Box 362142, Birmingham, AL 35236-2142