

PROVIDER DEMOGRAPHIC CHANGE FORM

**BlueShield of Northeastern 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 844-769-5876

Section I: Demographic Data

Name: Last _____ First _____ MI _____ NPI # _____ MEDICARE # _____ Practice Location Name _____ Group/Facility Name: (if applicable) _____ Primary Hospital Affiliation & Status: _____	Title: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DMD <input type="checkbox"/> DDS <input type="checkbox"/> DPM <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> OD <input type="checkbox"/> AUD <input type="checkbox"/> NP* <input type="checkbox"/> PA** <input type="checkbox"/> CNM* <input type="checkbox"/> CRNA** <input type="checkbox"/> Other: _____ <ul style="list-style-type: none"> <u>** Supervision Data Form required for PA/CRNA's</u> <u>*Agreement/Acknowledgement Form required for NP/CNM and collaborating/supervising Physician.</u> 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 _____
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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): _____

Termining 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 updated: **Recognition e-mail received from NCOA is required; Including Recognition Level, Locations, Effective Date/Term Date and Listing of Providers (Name, NPI). ***PLEASE ATTACH TO THIS FORM.**

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:		Phone:		Fax:	
Email:				Email:			
Handicapped Accessible <input type="checkbox"/> Yes <input type="checkbox"/> No * (if No, see Section IV)		Tax ID No:		Handicapped Accessible <input type="checkbox"/> Yes <input type="checkbox"/> No		Tax ID No:	
Doctors Hours (exact times)				Doctors Hours (exact times)			

AM- Mon _ _ Tue _ _ Wed _ _ Thur _ _ Fri _ _ Sat _ _ Sun _ _ PM- Mon _ _ Tue _ _ Wed _ _ Thur _ _ Fri _ _ Sat _ _ Sun _ _	AM Mon _ _ Tue _ _ Wed _ _ Thur _ _ Fri _ _ Sat _ _ Sun _ _ PM Mon _ _ Tue _ _ Wed _ _ Thur _ _ Fri _ _ Sat _ _ Sun _ _
Office Hours (exact times) AM- Mon _ _ Tue _ _ Wed _ _ Thur _ _ Fri _ _ Sat _ _ Sun _ _ PM- Mon _ _ Tue _ _ Wed _ _ Thur _ _ Fri _ _ Sat _ _ Sun _ _	Office Hours (exact times) AM- 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: <input type="checkbox"/> Service Site <input type="checkbox"/> Group Address <input type="checkbox"/> Remit Address <input type="checkbox"/> Other _____	Correspondence to: <input type="checkbox"/> Service Site <input type="checkbox"/> Group Address <input type="checkbox"/> Remit Address <input type="checkbox"/> 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 BlueShield of Northeastern 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:** _____