BlueCross BlueShield of Mississippi

It's good to be Blue.

PROVIDER UPDATE
Institutional Ancillary Provider

Submit changes for: **BCBSMS Only** ☐ **AHS Only** ☐ **Both** ☐ **Effective Date of Change:** _____

CONTACT INFORMATION

Requester Name/Title:	
Telephone #:	Fax #:
E-Mail:	

CURRENT INSTITUTIONAL ANCILLARY INFORMATION

WHAT'S CHANGING:

- ☐ Office Address/Appointment Phone
- ☐ Billing Address/Phone
- ☐ Correspondence Address/Phone
- ☐ National Provider Identifier
- ☐ Tax ID – Change in Tax ID also requires a full network application and contracts to be completed for each location under the new Tax ID.

TYPE OF CHANGE:

- ☐ Change – Complete Current and New Information fields.
- ☐ Add New – Adding a new location also requires a full network application and contracts to be completed for each location to be added.
- ☐ Close – Complete Current Information fields.

OFFICE ADDRESS CURRENT INFORMATION (Only populate if existing address is changing locations.)			**OFFICE ADDRESS NEW INFORMATION**		
Clinic/Facility Name:			Clinic/Facility Name:		
Physical Address:			Physical Address:		
City:	State:	Zip:	City:	State:	Zip:
Appointment Phone:	Fax:		Appointment Phone:	Fax:	
Tax ID:	NPI:		Tax ID:	NPI:	
Licensure/Certification:					

CORRESPONDENCE ADDRESS CURRENT INFORMATION (Only populate if existing address is changing locations.)			**CORRESPONDENCE OFFICE ADDRESS NEW INFORMATION**		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:	Fax:		Phone:	Fax:	
E-Mail:			E-Mail:		
Clinic/Facility Web-site:			Clinic/Facility Web-site:		

BILLING ADDRESS CURRENT INFORMATION (Only populate if existing address is changing locations.)			**BILLING OFFICE ADDRESS NEW INFORMATION**		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:	Fax:		Phone:	Fax:	

STATEMENT TO RELEASE INFORMATION

I hereby affirm that all information required and submitted by me is true to the best of my knowledge and belief. I understand that any misstatement may constitute grounds for summary dismissal as a Blue Cross & Blue Shield of Mississippi (BCBSMS) provider. I agree that I have a continuing affirmative duty to immediately inform BCBSMS of any material changes that may affect my professional status. I consent to the release of all information that may be relevant to an evaluation of my credentials, including information about disciplinary actions or other confidential or privileged information, to BCBSMS or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which I am a Blue Cross & Blue Shield of Mississippi provider. I release BCBSMS, its affiliates and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my credentials.

_____ Provider Name (Please Print)

_____ Signature

_____ Date

MAIL TO:	**FAX TO:**	**E-MAIL TO:**
Blue Cross & Blue Shield of Mississippi Attn: Provider Information Group 3545 Lakeland Drive Flowood, MS 39232	Attn: Provider Information Group 601-664-5107	ProviderInfo@bcbsms.com

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