

**Submit changes for:** **BCBSMS Only**    **AHS Only**    **Both**    **Effective Date of Change:** \_\_\_\_\_

CONTACT INFORMATION											
Requester Name/Title:											
Telephone #:					Fax #:						
E-Mail:											
PROVIDER INFORMATION											
Last Name:			First Name:				M.I.:		Title:		
Date of Birth:					Gender:                      Male                      Female						
SSN #:					NPI:						
Licensure:											
LOCATION INFORMATION – W-9 Form Required. Copy of current protocol must be submitted for a NP, CNM or CRNA. Attach additional copies of this page if updating more than one office location.											
<b>WHAT'S CHANGING:</b>					<b>TYPE OF CHANGE:</b>						
Office Address/Appointment Phone                      Billing Address/Phone Correspondence Address/Phone                      National Provider Identifier Tax ID – Adding new Tax ID for network providers requires submission of new Authorization Agreement, BCBS EDI Agreement and Provider Remote Access Agreement for the group.					Change – Complete Current and New Information fields. Add New – Complete New Information fields for Office, Correspondence and Billing Addresses as well as Directory Information. If new Tax ID, new Authorization Agreement, BCBS EDI Agreement and Provider Remote Access Agreement for the group must also be submitted. 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:		
DIRECTORY INFORMATION – All fields must be populated for your New Office Address Location unless Do Not Publish is selected.											
Wheel Chair Access:		Yes                      No		TDD Telephone #:				<b>DO NOT PUBLISH</b>			
<b>AVERAGE PATIENT WAIT TIME:</b>		0-15 Minutes		15-30 Minutes		30-45 Minutes		More than 45 Minutes			
<b>RECOMMENDED SCHEDULING TIME FOR ELECTIVE APPOINTMENTS:</b>											
1 Week or Less		1-2 Weeks		3-4 Weeks		4 Weeks or More		By Referral Only			
<b>PATIENTS ACCEPTED:</b>					Accepts New Patients                      Does Not Accept New Patients Open to Existing Patients Only                      Open to Existing Patients & Family Members of Existing Patients						
Languages Spoken:											
CORRESPONDENCE ADDRESS CURRENT INFORMATION (Only populate if existing address is changing locations.)					CORRESPONDENCE OFFICE ADDRESS NEW INFORMATION (Same as office address)						
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 (Same as office address)						
Address:					Address:						
City:		State:		Zip:		City:		State:		Zip:	
Phone:			Fax:			Phone:			Fax:		

**PROVIDER WORK HISTORY**

**Must be completed if adding new location.**

Chronologically list all work history for at least the past five years (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient, provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

Previous Clinic Name:  
Multiple Locations

Address:			Telephone #:
City:	State:	Zip:	Contact:
From: (MM/DD/YYYY)			To: (MM/DD/YYYY)

Previous Clinic Name:  
Multiple Locations

Address:			Telephone #:
City:	State:	Zip:	Contact:
From: (MM/DD/YYYY)			To: (MM/DD/YYYY)

Previous Clinic Name:  
Multiple Locations

Address:			Telephone #:
City:	State:	Zip:	Contact:
From: (MM/DD/YYYY)			To: (MM/DD/YYYY)

Previous Clinic Name:  
Multiple Locations

Address:			Telephone #:
City:	State:	Zip:	Contact:
From: (MM/DD/YYYY)			To: (MM/DD/YYYY)

**PROVIDER LEAVING PRACTICE**

**If joining a new practice, must complete New Location Information above.**

**REASON:**

Left Clinic                      Retired                      Deceased                      Other:

Clinic/Facility Name:	Clinic/Facility Tax ID: (All locations under Tax ID will be closed.)
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**NAME CHANGE**

**Attach copy of marriage license, divorce decree, etc.**

Current Name:	New Name:
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**PHYSICIAN SPECIALTY CHANGE**

**Attach copy of board certification, education, etc. to support change.**

Current Specialty:	New Specialty:
	PCP Specialist:

**PHYSICIAN HOSPITAL AFFILIATION CHANGE**

**Attach copy of hospital letter, etc. to support change.**

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