**** IMPORTANT: Please verify provider requesting change is participating with BCBSRI before submitting form. This is NOT an application for participation. If provider is not currently participating in the BCBSRI network, please visit BCBSRI.com and submit a request to participate ****

Practitioner Change Form

DIRECTIONS: Please check all that apply and fill in sections as directed.

❑ **Tax ID Change –** *Complete Sections 1 and 2.* ***Attach a completed W-9 form.***

❑ **Change in Practice Information**

- **Mailing and/or payment address for existing office** – *Complete Sections 1 and 2.*
- **Closing existing site, opening new site or joining existing practice** – *Complete Sections 1, 2, 3A, and 3B.*
- **Change in office hours, covering physicians and accepting/not accepting new patients** – *Complete Sections 1, 3A, and 3B.*

NOTE: If you are adding a new practice location in another state, please provide us with a copy of your license and federal DEA to practice in that state.

When completed, please fax the required documentation to (401) 459-2099 or email to ProvDB@bcbsri.org:

If you have any questions regarding this form, please call The Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050.

Section 1 – General Information

Practitioner name: ______________________ Date: ______________

Degree: ______________________ Date of birth: ______________

Name and title of person completing form: ______________________

E-mail address: ______________________ Phone number: ______________

National Provider Identifier(s)

NPI Type 1: ______________________ Tax ID number: ______________

NPI Type 2: ______________________ Tax ID number: ______________

Primary specialty: ______________________

Secondary specialty: ______________________

Do you speak a foreign language fluently? ❑ Yes ❑ No

Please list all languages spoken: ______________________

____

Description of requested change: ______________________

____

____

Section 2 – Mailing and/or Payment Address Change

New Mailing Address **Effective date of change:** ______________

Street: ______________________

City: ______________ State: ______________ ZIP: ______________

Old Mailing Address

Street: ______________ Phone: ______________ Fax: ______________

City: ______________ State: ______________ ZIP: ______________

New Payment Address **Effective date of change:** ______________

Street: ______________________

City: ______________ State: ______________ ZIP: ______________

Old Payment Address

Street: ______________ Phone: ______________ Fax: ______________

City: ______________ State: ______________ ZIP: ______________

Section 3A – Change in Practice Information
IMPORTANT: Please attach W-9 form

A ***CLOSING / ADDING ADDITIONAL SITES***

If this information requires a change in your practice(s) hours, covering physicians, and whether you are accepting/not accepting new patients, please also complete Section 3B on the next page.

Old Office

Name of Group/Clinic: ______

Name of Group/Clinic Manager: ______

Street: ______

City: ______ State: ______ ZIP: ______

Phone: (______) ______

Business E-mail: ______

Date practice closed (if applicable): ______

New Office #1 (Primary Office)

Effective date of change: ______

Name of Group/Clinic: ______

Name of Group/Clinic Manager: ______

Street: ______

City: ______ State: ______ ZIP: ______

Phone: (______) ______

Fax: (______) ______

Business E-mail: ______

Payment Address

Street: ______

City: ______ State: ______ ZIP: ______

Phone: (______) ______

Fax: (______) ______

Tax ID Number: ___ ___ – ___ ___ ___ ___ ___ ___ ___ ___

Type 2 NPI: ______

Mailing Address

Street: ______

City: ______ State: ______ ZIP: ______

Is this office handicapped accessible? ❑ Yes ❑ No

Is it equipped with TDD equipment for the hearing impaired? ❑ Yes ❑ No

Do any of your staff members speak a foreign language fluently? ❑ Yes ❑ No

Please list all languages spoken: ______

______

COMMENTS ______

New Office #2

Effective date of change: ______

Name of Group/Clinic: ______

Name of Group/Clinic Manager: ______

Street: ______

City: ______ State: ______ ZIP: ______

Phone: (______) ______

Fax: (______) ______

Business E-mail: ______

Payment Address ❑ ***Same as Primary Office Information***

Street: ______

City: ______ State: ______ ZIP: ______

Phone: (______) ______

Fax: (______) ______

Tax ID Number: ___ ___ – ___ ___ ___ ___ ___ ___ ___ ___

Type 2 NPI: ______

Mailing Address ❑ ***Same as Primary Office Information***

Street: ______

City: ______ State: ______ ZIP: ______

Is this office handicapped accessible? ❑ Yes ❑ No

Is it equipped with TDD equipment for the hearing impaired? ❑ Yes ❑ No

Do any of your staff members speak a foreign language fluently? ❑ Yes ❑ No

Please list all languages spoken: ______

______

New Office #3

Effective date of change: ______

Name of Group/Clinic: ______

Name of Group/Clinic Manager: ______

Street: ______

City: ______ State: ______ ZIP: ______

Phone: (______) ______

Fax: (______) ______

Business E-mail: ______

Payment Address ❑ ***Same as Primary Office Information***

Street: ______

City: ______ State: ______ ZIP: ______

Phone: (______) ______

Fax: (______) ______

Tax ID Number: ___ ___ – ___ ___ ___ ___ ___ ___ ___ ___

Type 2 NPI: ______

Mailing Address ❑ ***Same as Primary Office Information***

Street: ______

City: ______ State: ______ ZIP: ______

Is this office handicapped accessible? ❑ Yes ❑ No

Is it equipped with TDD equipment for the hearing impaired? ❑ Yes ❑ No

Do any of your staff members speak a foreign language fluently? ❑ Yes ❑ No

Please list all languages spoken: ______

______

Section 3B – Change in Practice Information

B **GENERAL INFORMATION**

☐ **Practice Information**

What is the average waiting time to obtain an appointment? *(Please respond with a specific waiting time. "PRN" is not acceptable.)*

Initial visits will be provided within ___________ weeks.

Symptomatic/non-urgent visits will be provided within ___________ weeks.

Urgent visits will be provided within ___________ hours.

Are you accepting new patients? ☐ Yes ☐ No

Which age groups do you treat? ☐ All ages ☐ 0-13 years ☐ 14-18 years ☐ 19-65 years ☐ 65+ years

☐ **New Office Hours** *Please indicate office hours at each location. (e.g., 9:00 a.m. –– 5:00 p.m.)*

Location	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Office #1							
Office #2							
Office #3							

☐ **Changes in Covering Physicians/Associates**

Please list current partners/associates in your practice and physicians/providers who cover for you, with their respective specialties.
If more than four practitioners, please use additional sheets.
Collaborative agreements and requirements are required for nurse practitioners, physician's assistants, nurse midwives, and clinical nurse specialists with prescriptive privileges.

NAME	DEGREE	SPECIALTY	PARTNER	COVERING	BOTH
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

Are you available, or do you have available coverage, 24 hours per day, seven days per week? ☐ Yes ☐ No

How do you provide this coverage? (Please check)

☐ Answering Service ☐ Answering machine (with pager or cell phone number)

☐ Call Forwarding ☐ Cell Phone ☐ Home Phone

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