**** 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 ****

Blue Cross Blue Shield of Rhode Island

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.
NP-PA Questionnaire is required for nurse practitioners, physician's assisants, and CNS or CNP license.

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

www.BCBSRI.com

500 Exchange Street • Providence, RI 02903-2699

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

5/10 **7/20** CON-7277