



# 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 mail it to:

**Provider Information Management and Operations**

Blue Cross & Blue Shield of Rhode Island  
500 Exchange Street, Providence, RI 02903

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**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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: \_\_\_\_\_





[www.BCBSRI.com](http://www.BCBSRI.com)

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