

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) 459-1774 or (401) 459-2099, or mail it to:

Contracting Department

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: _____

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: _____

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: _____



Your Plan for Life.™

www.BCBSRI.com

500 Exchange Street • Providence, RI 02903-2699

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