

Practitioner Change Form

DIRECTIONS: Please check all that apply and fill	in sections as directed.			
☐ Tax ID Change — Complete Sections 1 and 2. A	ttach a completed W-9 form.			
 Change in Practice Information Mailing and/or payment address for existi Closing existing site, opening new site or Change in office hours, covering physician 	joining existing practice — Complete Section			
NOTE: If you are adding a new practice to a copy of your license and federal DEA to	s with			
When completed, please fax the required do	ocumentation to (401) 459-1774 or (401) 459-2	099, or mail it to:		
Contracting Department Blue Cross & Blue Shield of Rhode Island 500 Exchange Street, Providence, RI 02903	3			
If you have any questions regarding this form, ple	ease 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:				
National Provider Identifier(s)				
NPI Type 1:	Tax ID n	Tax ID number: Tax ID number:		
NPI Type 2:	Tax ID n			
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 A	Address Change			
New Mailing Address Street:	· ·	Effective date of change:		
City:		ZIP:		
Old Mailing Address				
Street:	Phone:	Fax:		
City:		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: 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: 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? *Is it equipped with TDD equipment for the hearing impaired?* Pes No Do any of your staff members speak a foreign language fluently? \(\bigsigm\) Yes \(\bigsigm\) 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	y Office Information
Street:		
City:	State:	ZIP:
Phone: ()		
Fax: ()		
Tax ID Number:		
Type 2 NPI:		
Mailing Address	☐ Same as Primar	v Office Information
Street:	<u> </u>	, G
City:	State:	ZIP:
Is this office handicapped access	sihle?	□Yes □ No
Is it equipped with TDD equipmen		
Do any of your staff members spea		
Please list all languages spoken:		
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New Office #3		
Effective date of change:		
Name of Group/Clinic:		
Name of Group/Clinic Manager: _		
Street:		
City:		ZIP:
Phone: ()		
Fax: ()		
Business E-mail:		
Payment Address	☐ Same as Primar	v Office Information
Street:		,
City:	State:	7IP·
Phone: ()		
Fax: ()		
Tax ID Number:		
Type 2 NPI:	·	
Mailing Address	☐ Same as Primary	y Office Information
Street:		
City:	State:	ZIP:
Is this office handicapped access	sihle?	□Yes □ No
Is it equipped with TDD equipmen		
Do any of your staff members spea		
Please list all languages spoken:		nay: 🛥 165 🛥 140
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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. Yes ☐ No Are you accepting new patients? **O**-13 years ☐ All ages 14-18 years 19-65 years 65+ years Which age groups do you treat? **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 (Complete this section only if you are a PCP or you are employed by or covering for a PCP (i.e., nurse practitioner, physician's assistant). 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, and nurse midwives. NAME **DEGREE SPECIALTY** PARTNER COVERING **BOTH**

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Are you available, or do you have available coverage, 24 h	ours per day, seven c	lays per week?	es 🔲	l N
How do you provide this coverage? (Please check) Answering Service Call Forwarding	Answerir Cell Phor	ng machine (with pager or ce ne Home F	•	er)



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