Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Practitioner Demographic Changes

Complete and return with the W-9 and malpractice (liability) insurance by mail or fax to the address below. This form *must be* signed by the practitioner (*no signature stamps will be accepted*).

Today's Date:	Effective Date:	Provider Name:
DEA Certificate #:	Provider License #/State:	Individual NPI Number:
Medicaid #:	Medicare #:	Social Security # ***(required)***:
Experienced HIV/AIDS Provider: ☐ Yes ☐ No	Accepting new patients? ☐ Yes ☐ No	Language(s) [other than English]:

Type of Change:	☐ ADD	☐ UPDATE	☐ CORRECT	☐ CLOSE	☐ TERMINATE—allow 45 days prior to termination
Termination reason:					

Any nurse practitioner (NP), physician assistant (PA), registered nurse first assistant, or certified behavior analyst assistant (BCaBA) that has a collaborating relationship with the terminated licensed physician must complete an *Application for Non-Physician Health Care Practitioner* to be reassigned.

Change to:	☐ NAME/PROVIDER	☐ TELEPHONE/FAX	☐ EMAIL	☐ NPI	☐ TAXONOMY	☐ TAX ID *
	☐ ADDRESS	◯ Primary Office	◯ Additional Office	◯ Correspondence	◯ Remittance	◯ Medical Record

NPI (National Provider Identifier) Number:	Group—Entity NPI (Type 2):	Group Name:
	Group—Entity NPI (Type 2):	Group Name:

Taxonomy Code ***(required)***:	Primary Specialty:	Taxonomy Code ***(required)***:
	Second Specialty:	Taxonomy Code ***(required)***:
	Third Specialty:	Taxonomy Code ***(required)***:

Current Tax ID#: _____	Reason for New Tax ID#:* _____	**A copy of the W-9 form must be attached.*
☐ *Keep current Tax ID*	☐ *Joining an existing TIN/Practice*	☐ *New Name for existing Tax ID*
☐ *Terminate from current Tax ID*	☐ *Change in ownership*	☐ *Other:*
		☐ *New Business (use **Application for Practitioner Enrollment**)*

Please note: Addresses ***must*** be identified by street level information with the corresponding City, State and ZIP code, and as a valid United States Postal Service mailing address. If PO BOX information is used, the corresponding City, State and ZIP Code for the PO BOX must be provided, and there should be no street level information present.

Address A	☐ Old Address ☐ New Address	❍ Primary Office	❍ Additional Office	❍ Correspondence	❍ Remittance	❍ Medical Record
	Address:	STE:	City:	State:	ZIP Code:	
	Office Phone:	Office Fax:	Handicap accessible ***(required)***: ☐ Yes ☐ No	Public Transportation: ☐ Yes ☐ No		
	Primary/Additional office hours to see patients?	Mon _____-_____	Tue _____-_____	Wed _____-_____	Thu _____-_____	Fri _____-_____	Sat _____-_____	Sun _____-_____
Address B	☐ Old Address ☐ New Address	❍ Primary Office	❍ Additional Office	❍ Correspondence	❍ Remittance	❍ Medical Record
	Address:	STE:	City:	State:	ZIP Code:	
	Office Phone:	Office Fax:	Handicap accessible ***(required)***: ☐ Yes ☐ No	Public Transportation: ☐ Yes ☐ No		
	Primary/Additional office hours to see patients?	Mon _____-_____	Tue _____-_____	Wed _____-_____	Thu _____-_____	Fri _____-_____	Sat _____-_____	Sun _____-_____
Address C	☐ Old Address ☐ New Address	❍ Primary Office	❍ Additional Office	❍ Correspondence	❍ Remittance	❍ Medical Record
	Address:	STE:	City:	State:	ZIP Code:	
	Office Phone:	Office Fax:	Handicap accessible ***(required)***: ☐ Yes ☐ No	Public Transportation: ☐ Yes ☐ No		
	Primary/Additional office hours to see patients?	Mon _____-_____	Tue _____-_____	Wed _____-_____	Thu _____-_____	Fri _____-_____	Sat _____-_____	Sun _____-_____
Address D	☐ Old Address ☐ New Address	❍ Primary Office	❍ Additional Office	❍ Correspondence	❍ Remittance	❍ Medical Record
	Address:	STE:	City:	State:	ZIP Code:	
	Office Phone:	Office Fax:	Handicap accessible ***(required)***: ☐ Yes ☐ No	Public Transportation: ☐ Yes ☐ No		
	Primary/Additional office hours to see patients?	Mon _____-_____	Tue _____-_____	Wed _____-_____	Thu _____-_____	Fri _____-_____	Sat _____-_____	Sun _____-_____

All members can make an appointment and be treated at ***Address***: ***A*** ☐ ***B*** ☐ ***C*** ☐ ***D*** ☐	Provider is a Hospitalist at ***Address***: ***A*** ☐ ***B*** ☐ ***C*** ☐ ***D*** ☐

	Name/Address	***Status***	***Effective Date***
Hospital Affiliations			

Office email:	Physician email:
Practitioner's signature *(Signature not required if form is submitted online through provider portal):*	Date

Mail or fax this completed form to the address below that is located closest to your primary office as: Excellus BlueCross Blue Shield, Attn: Provider File Maintenance

For Rochester area: 165 Court Street, Rochester, NY 14647 / Fax Number: 1-800-676-6285	*For CNY, Southern Tier, Utica/Watertown, PA & VT areas:* 333 Butternut Drive, Syracuse, NY 13214 / Fax Number: 1-800-676-6285