



CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.
 Provider Information and Credentialing
 Mailstop CG-41
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 Owings Mills, MD 21117-0825

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Change in Provider Information

INSTRUCTIONS: Use this form to report provider information changes.
 Send this form along with your letterhead to the address or fax number above.

GENERAL INFORMATION										
Office Contact:					Phone Number:			Date: / /		
Practice Name:					Tax ID:					
Provider Name:			Social Security Number:		Provider Number:		National Provider Identifier:			
ADDRESS OR PHONE NUMBER CHANGE – Check all boxes that apply for the type of change										
Add New <input type="checkbox"/>	Cancel <input type="checkbox"/>	Change <input type="checkbox"/>	Effective Date: / /		Add New <input type="checkbox"/>	Cancel <input type="checkbox"/>	Change <input type="checkbox"/>	Effective Date: / /		
TYPE OF CHANGE					TYPE OF CHANGE					
Office <input type="checkbox"/>	Mailing <input type="checkbox"/>	Payee/Billing/Vendor <input type="checkbox"/>	Directory <input type="checkbox"/>	Tax <input type="checkbox"/>	Office <input type="checkbox"/>	Mailing <input type="checkbox"/>	Payee/Billing/Vendor <input type="checkbox"/>	Directory <input type="checkbox"/>	Tax <input type="checkbox"/>	
Address 1:					Address 1:					
Address 2:					Address 2:					
City:		State:		Zip:		City:		State:		Zip:
Phone Number:			Fax Number:		Phone Number:			Fax:		
Is the Provider a Primary Care Physician (Family Practitioner, Internist, Pediatrician)? Yes <input type="checkbox"/> No <input type="checkbox"/>										
Is this a new office location? Yes <input type="checkbox"/> No <input type="checkbox"/>					If yes, attach a list of providers at this location					
NAME CHANGE – For an individual name change, attach copy of marriage license, divorce decree, etc.										
Previous Name:				New Name:			Effective Date: / /			
TAX ID CHANGE – Attach billing authorization form or W9 for each provider										
Previous Tax ID:				New Name:			Effective Date: / /			
PROVIDER LEAVING PRACTICE – If joining a new practice, submit uniform credentialing form										
Provider Name:							Effective Date: / /			
Reason for Leaving:	Leaving Service Area <input type="checkbox"/>	Deceased <input type="checkbox"/>	Retired <input type="checkbox"/>	Joining Another Practice <input type="checkbox"/>	Other:					
Check One: Open Panel <input type="checkbox"/> Closed Panel <input type="checkbox"/>										
Provider Name:										
Reason:							Effective Date: / /			
SPECIALITY CHANGE										
Previous Specialty:				New Specialty:						
Is Provider board certified in this specialty? Yes <input type="checkbox"/> No <input type="checkbox"/>					If yes, attach a copy of board certification.					
AUTHORIZED SIGNATURE										
Person authorized to make change (Print Name):										
Signature:				Title:			Date: / /			