

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.
 Provider Information and Credentialing
 Mailstop CG-41
 10455 Mill Run Circle
 Owings Mills, MD 21117-0825

Phone: 410-872-3500
 Toll Free: 877-269-9593
 Fax: 410-872-4107

CHANGE IN PROVIDER INFORMATION

(Please submit your letterhead with this form)

GENERAL INFORMATION			
OFFICE CONTACT:		PHONE NUMBER:	DATE: / /
PRACTICE NAME:		TAX ID:	
PRACTITIONER NAME:	SSN:	PROVIDER #:	NPI:

ADDRESS OR PHONE NUMBER CHANGE CHECK ALL BOXES THAT APPLY FOR TYPE OF CHANGE									
ADD NEW <input type="checkbox"/>	CANCEL <input type="checkbox"/>	CHANGE <input type="checkbox"/>	EFF DATE / /		ADD NEW <input type="checkbox"/>	CANCEL <input type="checkbox"/>	CHANGE <input type="checkbox"/>	EFF 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:		FAX:			PHONE:		FAX:		

IS THE PROVIDER A PRIMARY CARE PHYSICIAN (FAMILY PRACTITIONER, INTERNIST, PEDIATRICIAN)? YES NO

IS THIS A NEW OFFICE LOCATION? YES NO IF YES, ATTACH LIST OF PROVIDERS AT THIS LOCATION

NAME CHANGE FOR INDIVIDUAL NAME CHANGE, ATTACH COPY OF LICENSE, DIVORCE DECREE, ETC

PREVIOUS NAME:	NEW NAME:	EFF DATE / /
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TAX ID CHANGE ATTACH BILLING AUTHORIZATION FORM FOR EACH PRACTITIONER

PREVIOUS TAX ID:	NEW TAX ID:	EFF DATE / /
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PROVIDER LEAVING PRACTICE IF JOINING NEW PRACTICE, SUBMIT UNIFORM CREDENTIALING FORM

PROVIDER NAME:	EFF DATE / /
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REASON FOR LEAVING:	LEAVING SERVICE AREA <input type="checkbox"/>	DECEASED <input type="checkbox"/>	RETIRED <input type="checkbox"/>	JOINING ANOTHER PRACTICE <input type="checkbox"/>	OTHER:
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OPEN / CLOSE PANEL (CIRCLE ONE)

PROVIDER NAME:	
REASON:	EFF DATE / /

SPECIALTY CHANGE

PREVIOUS SPECIALTY:	NEW SPECIALTY:
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IS PROVIDER BOARD CERTIFIED IN THIS SPECIALTY? YES NO IF YES, ATTACH COPY OF BOARD CERT.

AUTHORIZED SIGNATURE

PERSON AUTHORIZED TO MAKE CHANGE & TITLE:	
AUTHORIZATION SIGNATURE:	DATE / /



FOR PROVIDER USE ONLY

This form is for reporting provider changes to CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.

You can mail or fax this form.

BY MAIL:

Mail this completed form, your practice letterhead and any required attachments to:

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.
Provider Information & Credentialing
Mailstop CG-41
10455 Mill Run Circle
Owings Mills, MD 21117-0825

BY FAX:

Fax this completed form, your practice letterhead and any required attachments to:
410-872-4107

QUESTIONS?

Contact us at 410-872-3500 or toll-free at 877-269-9593.