Dental Provider Information Change Form

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Use this form to update demographic information, such as addresses, tax ID, phone numbers, etc. Questions or changes related to contracts and networks should be directed to the BlueDental team at 1-888-271-7806.

Requested changes apply to the following provider: (Required information)

Provider Name	Degree (if applicable)

NPI Number	Tax ID Number

Required for individual providers only. Check all that apply:

☐ PCP (actively practicing as a PCP) ☐ Office Based ☐ Hospital Based

Group Name (if applicable)	Group/Organization NPI Number

INSTRUCTIONS

- **For tax ID changes, complete sections 3 through 12 to update or verify information.**
- **For all other changes, complete only the applicable sections.**

1. Provider Name Change

Name	Degree (if applicable)

2. Group/Organization NPI Number Change

Old Organizational NPI	New Organizational NPI	Effective date (mm/dd/yyyy)
		/ /

3. Tax ID Changes ☐ Add Tax ID ☐ Terminate Tax ID

Required: For all tax ID changes, complete sections 3 - 12 of this form to update or verify information.

Add Tax ID Number	Date provider started billing with this tax ID (mm/dd/yyyy)
	/ /
Group Name	Group NPI Number
Terminate Tax ID Number	Last service date using this tax ID (mm/dd/yyyy)
	/ /

Reason for change:

4. ARE YOU ACCEPTING NEW PATIENTS? ☐ Yes ☐ No

5. Specialty - What specialty are you ***actively*** practicing?

Primary	Board Certified
	☐ Yes ☐ No
Secondary	Board Certified
	☐ Yes ☐ No

Check all that apply: ☐ PCP (actively practicing as a PCP) ☐ Office Based ☐ Hospital Based

6. Business Email – Not a personal email address

Business Email

7. Business Website URL

Website

Important Information about Addresses:

- Blue Cross® Blue Shield® of Arizona (BCBSAZ) sends claim payments to the provider's billing address. Unless a separate mailing address has been specified, other correspondence (including contract updates) is also sent to the billing address. An exception is medical and/or dental records requests, which are sent to the primary location address if a separate medical and/or dental records address is not specified.
- To update addresses, a signed notification from the provider (such as this form) is required and 60 days advance notice is requested to avoid delays. Please also inform the post office of any address changes that require temporary mail forwarding.
- For professional providers, the primary address must be a physical location in Arizona, where services are performed.
- For facilities/ancillary providers, you must complete a new **contract application-information form** to change your primary or additional address.

8. Primary Address/Phone/Office Hours – Physical location where services are performed							
Street Address						Suite	
City						State	Zip
Phone			Fax			Effective Date (mm/dd/yyyy)	/ /
Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time							
End Time							

9. Billing Address – Contracted provider payments will be sent to this address		
Street Address	Suite	
City	State	Zip
Phone	Fax	Effective Date (mm/dd/yyyy) / /

10. Mailing Address – If no mailing address is specified, correspondence will be sent to the billing address		
Street Address	Suite	
City	State	Zip
Phone	Fax	Effective Date (mm/dd/yyyy) / /

11. Medical and/or Dental Records – If different than primary address		
Street Address	Suite	
City	State	Zip
Phone	Fax	Effective Date (mm/dd/yyyy) / /

12. Additional Office(s) – ☐ Add this address ☐ Correct this address ☐ Remove this address

For individual providers, add only locations where the provider is actively practicing on a regular basis (use an attached sheet if necessary). Do not include locations where the provider works occasionally or covers for other providers.

Street Address	Suite	
City	**State**	**Zip**
Phone	**Fax**	**Effective Date (mm/dd/yyyy)**
		/ /

Office Hours for Additional Office(s)

Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time							
End Time							

13. Privileges (Hospital / Surgical Facilities) – If necessary, use an attached sheet to indicate more privileges changes

☐ Add this privilege ☐ Remove this privilege

Facility Name ☐ Active ☐ Courtesy ☐ Provisional

Additional information and comments:

Authorized [Electronic] Signature

I am _____, and I verify that I am authorized to submit this change form on behalf of the provider named above. I agree that by entering my name in the authorized [electronic] signature field below, I am authorizing the changes indicated in this form.

/s/_____ _____

Authorized [Electronic] Signature Date

SAVE, attach, and email to ProviderApps@dominionnational.com or fax to BlueDental℠ Administrator at 1-888-345-2040

Questions? Call 1-888-271-7806