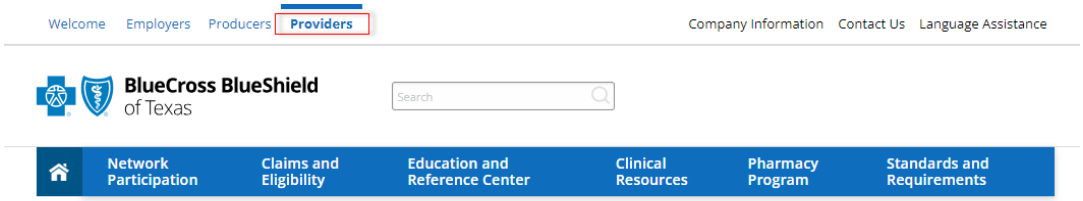
Demographic Change Form User Guide

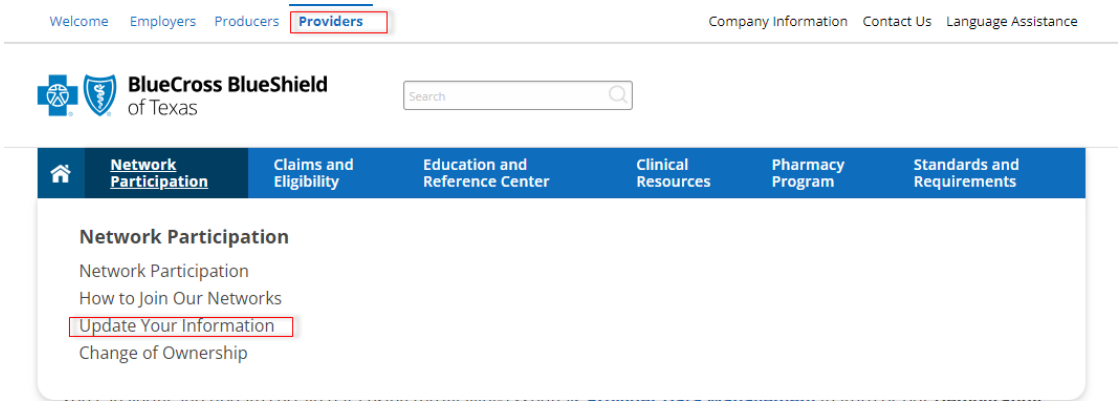
Access the Demographic Change Form

1. For best results use the **Google Chrome** browser.

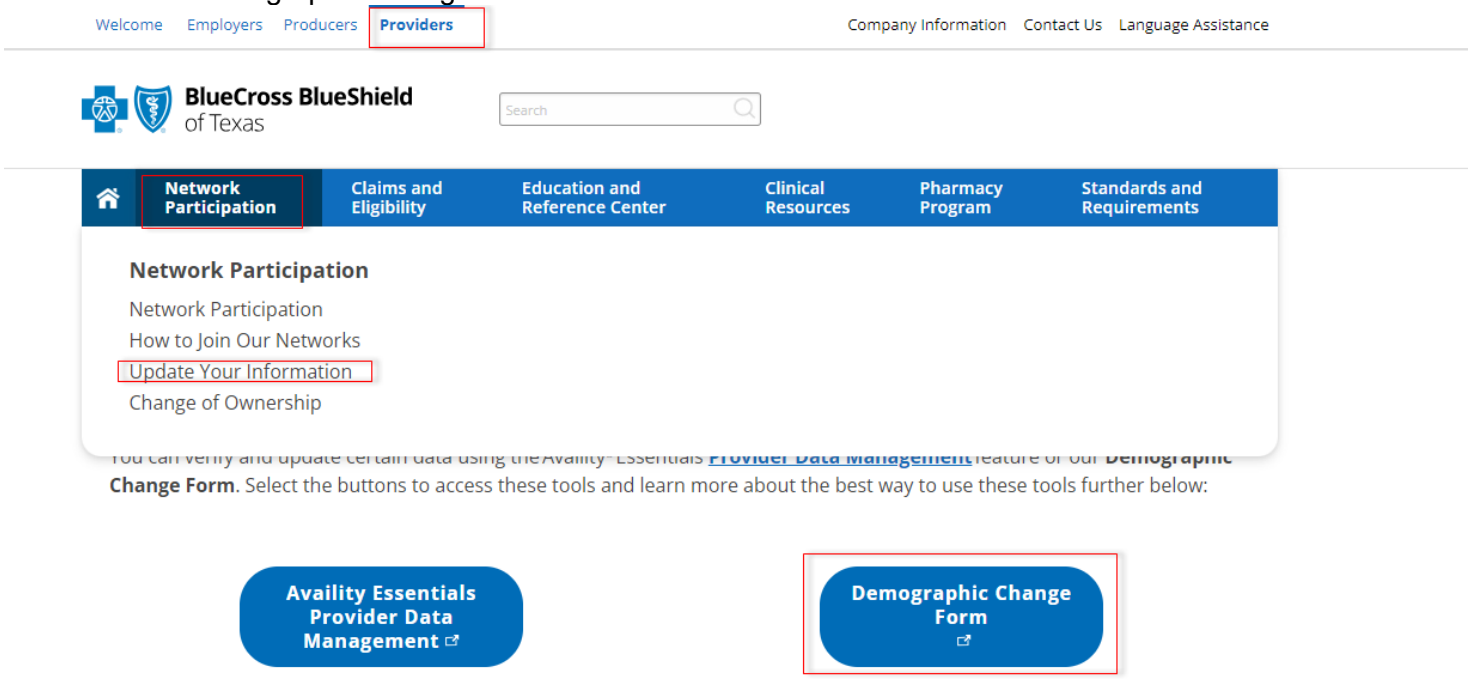
2. To access the form from the Blue Cross Blue Shield of Texas website, click the **Providers** tab.



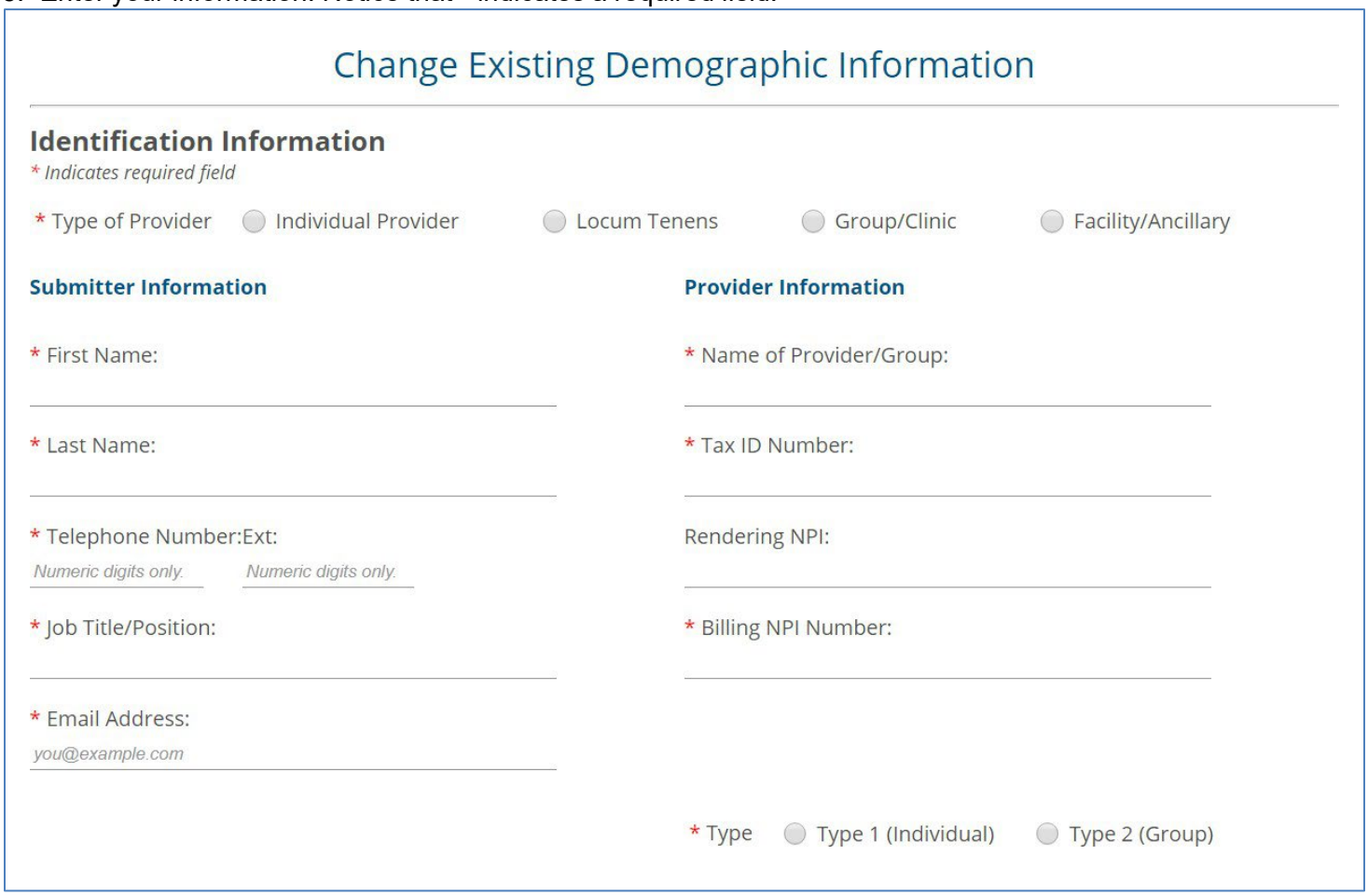
3. On the **Providers** Tab, select the **Network Participation** tab and then select **Update Your Information** from the list of options.



4. Select Demographic Change Form.



5. Enter your information. Notice that * indicates a required field.



Change Existing Demographic Information

Identification Information

** Indicates required field*

* Type of Provider ○ Individual Provider ○ Locum Tenens ○ Group/Clinic ○ Facility/Ancillary

Submitter Information

* First Name:

* Last Name:

* Telephone Number: Ext:

Numeric digits only. Numeric digits only.

* Job Title/Position:

* Email Address:

you@example.com

Provider Information

* Name of Provider/Group:

* Tax ID Number:

Rendering NPI:

* Billing NPI Number:

* Type ○ Type 1 (Individual) ○ Type 2 (Group)

6. * **Type of Provider** (**Note:** Form needs to be completed and submitted for **each** applicable provider and/or group provider record ID#)
   A. Individual Provider is a provider who will not be employing another professional provider
      a. A provider who will be using his/her social security number (SSN) for tax purposes
      b. A provider whose Federal Tax Identification Number (TIN) is legally in the provider's name
      c. A provider who is not incorporated
      d. A provider who practice exclusively in an inpatient or freestanding facility. Eligible specialties include, but are not limited to, Anesthesia, Emergency Medicine, Radiology, Pathology, Neonatology & Hospitalist.
   B. Locum Tenens is a provider who temporarily fulfils the duties of another provider. These professionals are still governed by their respective regulatory bodies
   C. Group/Clinic
      a. A provider who has a practice with more than one professional provider
      b. A provider whose Federal Tax Identification Number (TIN) has a corporate legal name
      c. A provider whose billing entity is incorporated
   D. Facility/Ancillary are inpatient or freestanding facilities or ancillary (i.e., DME, Hearing Aid, Rehab) providers.

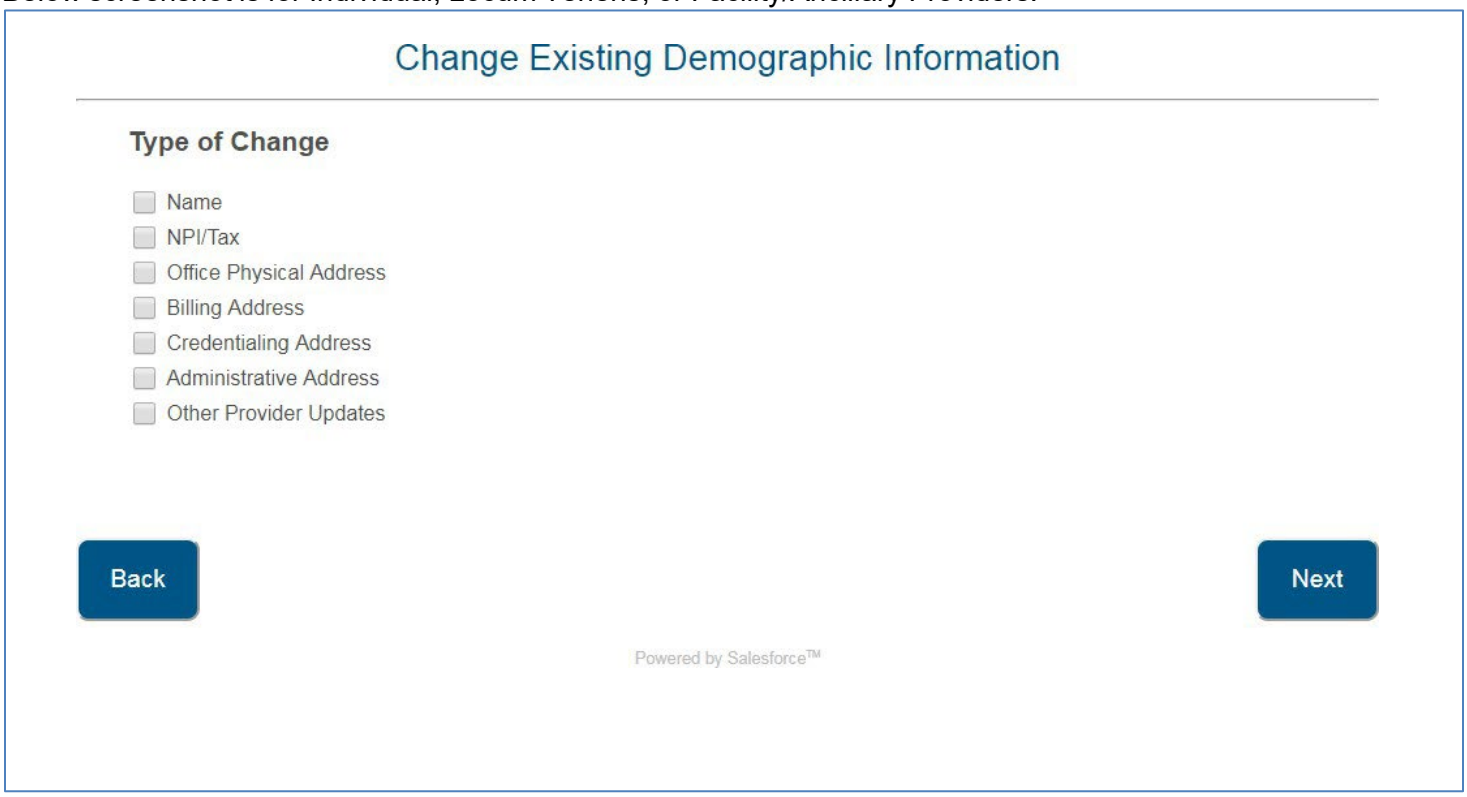
7. **Submitter Information**

   Required contact information of person completing the Demographic Change Form, should we have questions on the data submitted.

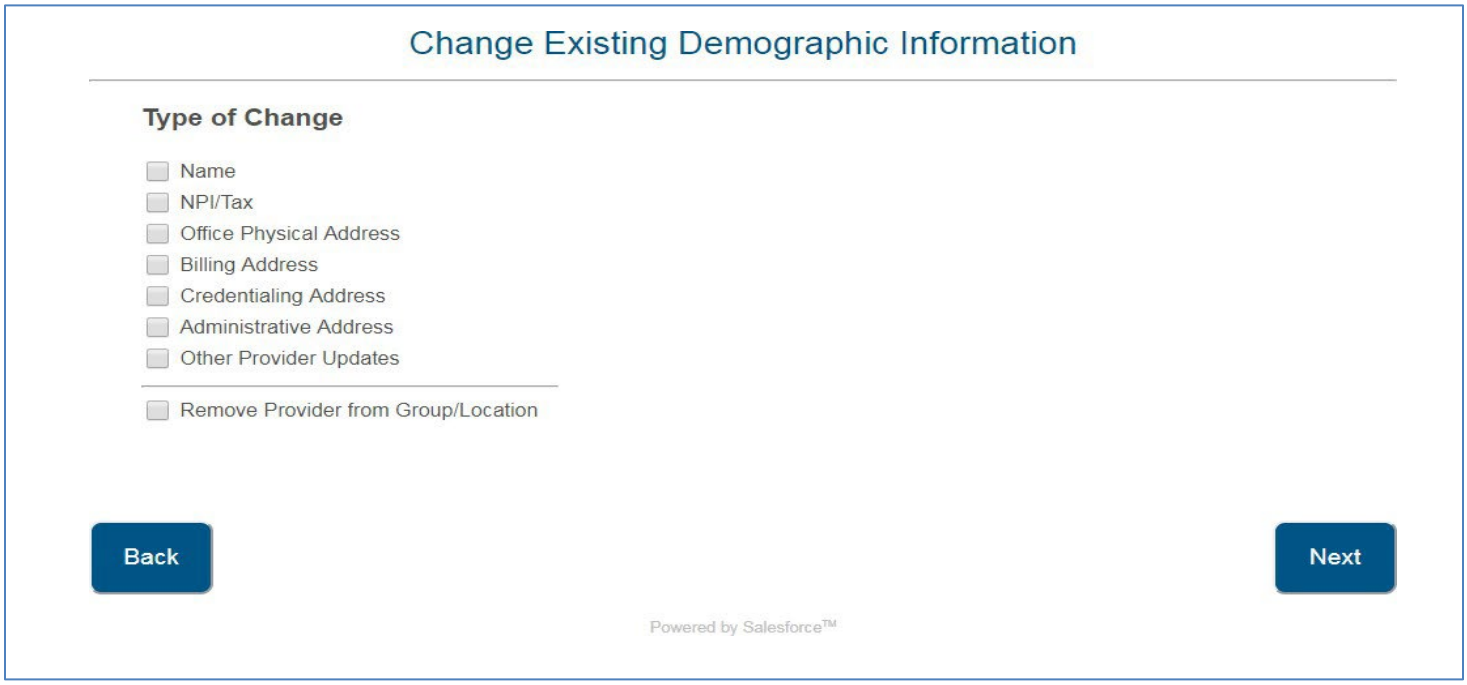
   - First and Last Name
   - Daytime Telephone Number
   - Job Title/Position
   - Email Address

8. **Provider Information**
   - Name of Provider/Group
   - Tax ID
   - Rendering NPI -A National Provider Identifier (NPI) is a 10-digit numerical identifier for providers of health care services. Type 1 is at the practitioner level. It is a personal identifying number for the individual healthcare provider. An individual is eligible for only one NPI.
   - Billing NPI Number - A National Provider Identifier (NPI) is a 10-digit numerical identifier for organizations such as physician groups, facilities, hospitals, home health agencies, labs and durable medical equipment (DME) providers.
     - Organizations must determine if they have "subparts" that need to be uniquely identified in HIPAA standard transactions with their own NPIs. A subpart is a component of an organization health care provider that furnishes health care and is not itself a separate legal entity.
     - If an individual is a health care provider and is incorporated, they may need to obtain an NPI for themselves (Type 1) and an NPI for their corporation or **limited liability company** (LLC) (Type 2).
       See the Centers for Medicare & Medicaid Services (CMS) National Plan and Provider Enumeration System to search the NPI Registry or to apply for your NPI number.

Below screenshot is for Individual, Locum Tenens, or Facility/Ancillary Providers:

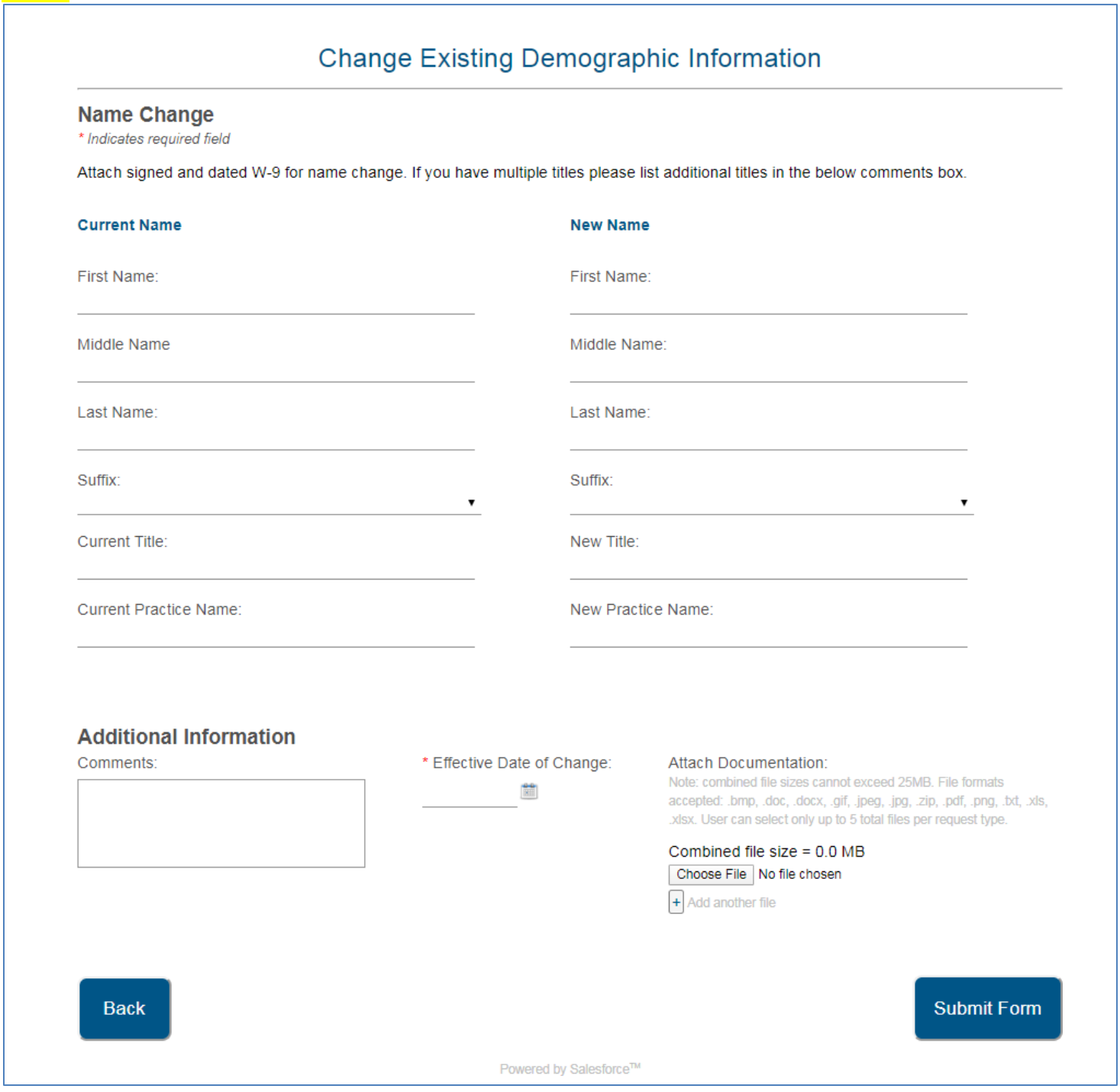


Below screenshot is for Group/Clinic use. It has the “Remove Provider from Group/Location” option at the bottom:

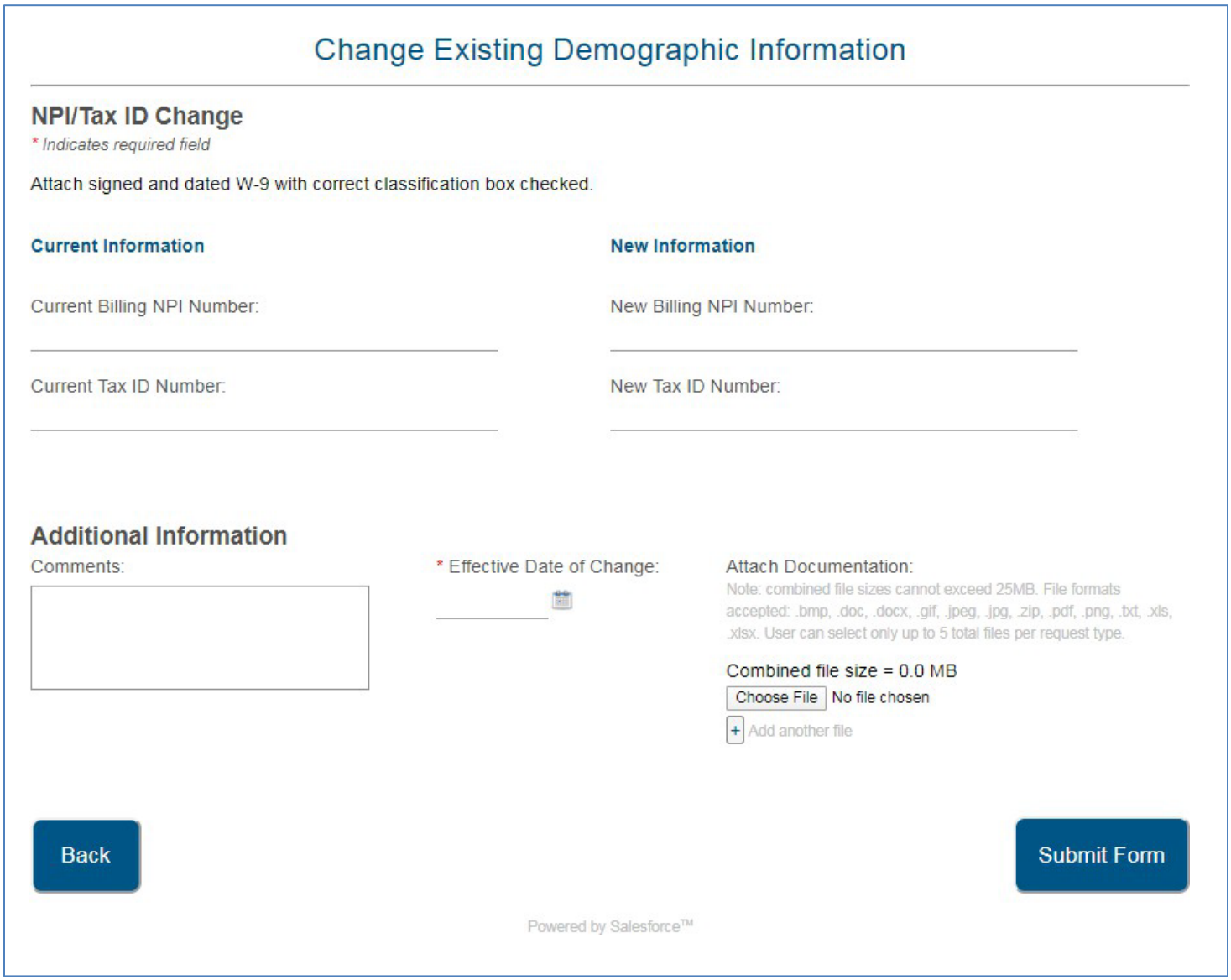


Next Screenshots are in chronological order based on the Type of Change selected in the previous screenshot

Name:



NPI/Tax ID:


Change Existing Demographic Information
NPI/Tax ID Change
* Indicates required field
Attach signed and dated W-9 with correct classification box checked.
Current Information
New Information
Current Billing NPI Number:
New Billing NPI Number:
Current Tax ID Number:
New Tax ID Number:
Additional Information
Comments:
* Effective Date of Change:
Attach Documentation:
Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.
Combined file size = 0.0 MB
Choose File
No file chosen
Add another file
Back
Submit Form
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Office Physical Address/Satellite location: Complete all information.
For the Primary Location reply:

"Yes", will replace current main physical location information.
"No" adds information as a directory location/satellite address.

Office Physical Address/Telephone/Fax/Email/Hours of Operation Change

* Indicates required field

Complete a separate form for each office physical address change request. This information is utilized for the member directories. A P.O. Box address will not be accepted as an official physical address. If your primary address change involves moving to a different county, this could impact your claims payment.

Current Office Physical Address

Address Line 1:
Address Line 2:
City:
State: Zip Code:
Telephone Number: Ext:
Numeric digits only
Email:
you@example.com
Fax Number:
Numeric digits only. For example: 1234567890

New Office Physical Address

Address Line 1:
Address Line 2:
City:
State: Zip Code:
Telephone Number: Ext:
Numeric digits only
Email:
you@example.com
Fax Number:
Numeric digits only. For example: 1234567890
Primary Location: Yes No
Supervising Physician:
Accepting New Patients:

Hours of Operation Change

For more than one set of hours for same day, please note in the comments box below.

Open 24/7

Mon to Wed to Fri to Sun to
Tue to Thu to Sat to

Americans with Disabilities Act (ADA)

* Are the following standards in accordance with the Americans with Disabilities Act? Yes No

If yes, please check at least one of the following

Side Accessible
Parking Accessibility
Exterior Building
Interior Building
Exam Room
Exam Table
Office Reception Area
Close Proximity to Public Transportation
Restroom
Scale

Treating Categories

* Does the provider treat the following?

Please check at least one

Homebound
Homeless
Blindness or Visually Impaired
Chronic Illness
Serious Mental Illness
Co-occurring Disorders
HIV/AIDS
Physical Disabilities
Deafness or Hard of Hearing

Additional Information

Comments:
* Effective Date of Change:
Attach Documentation:
Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.
Combined file size = 0.0 MB
Choose File No file chosen
Add another file

Back Submit Form

Billing Address:

Change Existing Demographic Information

Billing Address/Telephone/Fax/Email Change

* *Indicates required field*

Changes requested to a group's information will only be accepted if submitted by the group. *Supporting documentation must be* submitted on the group letterhead.

Current Billing Address

Address Line 1:

Address Line 2:

City:

State: Zip Code:

Telephone Number: Ext:

Numeric digits only. *Numeric digits only.*

Email:

you@example.com

Fax Number:

Numeric digits only. For example: 1234567890

New Billing Address

Address Line 1:

Address Line 2:

City:

State: Zip Code:

Telephone Number: Ext:

Numeric digits only. *Numeric digits only.*

Email:

you@example.com

Fax Number:

Numeric digits only. For example: 1234567890

Additional Information

Comments:

* Effective Date of Change:

Attach Documentation:

Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.

Combined file size = 0.0 MB

Choose File No file chosen

+ Add another file

Back

Submit Form

Credentialing Address:

Change Existing Demographic Information

Credentialing Address/Telephone/Fax/Email Change

* *Indicates required field*

Changes requested to a group's information will only be accepted if submitted by the group. *Supporting documentation must be* submitted on the group letterhead.

Current Credentialing Address

Address Line 1:

Address Line 2:

City:

State: Zip Code:

Telephone Number: Ext:

Numeric digits only. *Numeric digits only.*

Email:

you@example.com

Fax Number:

Numeric digits only. For example: 1234567890

Credentialing Contact Name:

New Credentialing Address

Address Line 1:

Address Line 2:

City:

State: Zip Code:

Telephone Number: Ext:

Numeric digits only. *Numeric digits only.*

Email:

you@example.com

Fax Number:

Numeric digits only.

Additional Information

Comments:

* Effective Date of Change:

Attach Documentation:

Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.

Combined file size = 0.0 MB

Choose File No file chosen

+ Add another file

Back Submit Form

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Administrative Address:

Change Existing Demographic Information

Administrative Address/Telephone/Fax/Email Change

* *Indicates required field*

Changes requested to a group's information will only be accepted if submitted by the group. *Supporting documentation must be* submitted on the group letterhead.

Current Administrative Address

Address Line 1:

Address Line 2:

City:

State: Zip Code:

Telephone Number: Ext:

Numeric digits only. *Numeric digits only.*

Email:

you@example.com

Fax Number:

Numeric digits only. For example: 1234567890

Administrative Contact Name:

New Administrative Address

Address Line 1:

Address Line 2:

City:

State: Zip Code:

Telephone Number: Ext:

Numeric digits only. *Numeric digits only.*

Email:

you@example.com

Fax Number:

Numeric digits only. For example: 1234567890

Additional Information

Comments:

* Effective Date of Change:

Attach Documentation:

Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.

Combined file size = 0.0 MB

Choose File No file chosen

+ Add another file

Back Submit Form

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Other Provider Updates:

Change Existing Demographic Information

Other Provider Updates

* Indicates required field

Current Information

Hospital Privilege (list all):

Ambulatory Surgery Center Privileges (list all):

License Number:

Specialty:

Subspecialty:

Specialty Effective Date:

Specialty Certification Date:

Board Certified: Yes No

Provide Lactation Services: Yes No

New Information

Hospital Privilege (list all):

Ambulatory Surgery Center Privileges (list all):

License Number:

Specialty:

Subspecialty:

Specialty Effective Date:

Specialty Certification Date:

Board Certified: Yes No

Provide Lactation Services: Yes No

Date Of Birth:

DEA Number:

DEA Number Expiration Date:

Languages (spoken or written):

Medical School Name:

Date of Graduation:

Residency Hospital Name:

Residency Period:

From To

Ethnicity:

Additional Information

Comments:

* Effective Date of Change:

Attach Documentation:

Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.

Combined file size = 0.0 MB

Choose File No file chosen

+ Add another file

Back

Submit Form

Remove Provider from Group/Location:

Remove Provider from Group/Location

** Indicates required field*

If you are removing a provider from more than two service locations, please Attach an Excel file with all applicable locations.

Individual Provider Information

* Individual Provider Name:

Individual's Type 1 NPI:

Other ID Number (Eg: Medicaid #, API #, LTSS #, TPI #):

Provider Location Information

☐ Remove Provider from all locations on file

Address Line 1:

Address Line 2:

City:

State: Zip Code:

* Reason for leaving:

* Effective Date of Termination:

☐ Add another location for removal

Additional Information

Comments:

Attach Documentation:

Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.

Combined file size = 0.0 MB

Choose File No file chosen

+ Add another file

* ☐ I certify that the information submitted within this form is accurate and complete.

Back Submit Form