Access the Demographic Change Form

- 1. For best results use the Google Chrome browser.
- 2. To access the form from the <u>Blue Cross Blue Shield of Texas website</u>, click the **Providers** tab.

Welco	me Employers	Producers Providers		Co	ompany Information	Contact Us Language Assistance
₿.	BlueCro of Texas	ss BlueShield	Search	Q		
ñ	Network Participation	Claims and Eligibility	Education and Reference Center	Clinical Resources	Pharmacy Program	Standards and Requirements

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

Welco	ome Employers P	roducers Providers]	Com	pany Information Co	ntact Us Language Assistance
Ø.	BlueCross of Texas	BlueShield	Search	Q		
ñ	<u>Network</u> Participation	Claims and Eligibility	Education and Reference Center	Clinical Resources	Pharmacy Program	Standards and Requirements
	Network Partic	ipation				
I H	letwork Participat low to Join Our Ne	ion etworks				
	How to Join Our Networks Update Your Information Change of Ownership					
	0					

4. Select Demographic Change Form.



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

Identification Information * Indicates required field			
* Type of Provider 🛛 Individual Provider	O Locum Tenens	Group/Clinic	Facility/Ancillar
Submitter Information	Provide	er Information	
* First Name:	* Name	of Provider/Group:	
* Last Name:	* Tax ID	Number:	
* Telephone Number:Ext: Numeric digits only. Numeric digits only.	Renderi	ng NPI:	
* Job Title/Position:	* Billing	NPI Number:	
* Email Address: you@example.com			
	* Type	Type 1 (Individual)	Type 2 (Group)

- 6. * <u>Type of Provider</u> (Note: Form needs to be completed and submitted for <u>each</u> 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.

- o First and Last Name
- Daytime Telephone Number
- $\circ \quad \text{Job Title/Position} \\$
- 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 <u>search the NPI Registry</u> 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:

Type of Change		
Name		
NPI/Tax		
Office Physical Address		
Billing Address		
Credentialing Address		
Administrative Address		
Other Provider Updates		
Remove Provider from Group/Location		

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

Cha	inge Existing De	mograp	hic Information
Name Change * Indicates required field			
Attach signed and dated W-9 for name ch	ange. If you have multiple	titles please I	ist additional titles in the below comments box.
Current Name		New Name	•
First Name:		First Name	
Middle Name		Middle Na	ne:
Last Name:		Last Name	:
Suffix:		Suffix:	τ.
Current Title:		New Title:	
Current Practice Name:		New Pract	ice Name:
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, .bt, .> .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
_			

NPI/Tax ID:



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.

impact your claims payment.			
Current Office Physical Address		New Office Physical Address	
Address Line 1:		Address Line 1:	
Address Line 2:		Address Line 2:	_
City.		City.	
State Zin Code		State Zin Code	
Telephone Number Ext: Numeric digits only Numeric digits on	ly:	Telephone Number Ext Numeric digits only Numeric digits only	
Email: you@example.com		Email: you@example.com	
Fax Number:		Fax Number:	
Numerie digita only. For example: 1234567890		Numeric digite only: For example: 1234567890	-0
		Primary Location: Yes	
		Supervising Physician:	
		Accepting New Patients.	
Hours of Operation Change	e day, please note in the comm	ents box below.	
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Billing Address:

Billing Address/Telephone/Fax/F	mail Change			
Indicates required field	inun onunge			
Changes requested to a group's information v he group letterhead.	vill only be accepted if submitted	I by the group. Supporting documentation must be submitted on		
Current Billing Address	New E	illing Address		
Address Line 1:	Addre	ss Line 1:		
Address Line 2:	Addre	ss Line 2:		
City:	City:			
State: Zip Code:	State:	Zip Code:		
Felephone Number: Ext:	Teleph	one Number: Ext:		
Numeric digits only. Numeric digits only.	Numer	c digits only. Numeric digits only.		
Email:	Email:			
you@example.com	you@e	xample.com		
Fax Number:	Fax N	umber:		
Numeric digits only. For example: 1234567890	Numer	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, .bt, .xis, .xksx. User can select only up to 5 total files per request type. Combined file size = 0.0 MB Choose File No file chosen		
Back		Submit Form		

Credentialing Address:

Credentialing Address/Telephon * Indicates required field	ne/Fax/Email Change	
Changes requested to a group's information the group letterhead.	will only be accepted if subm	nitted by the group. Supporting documentation must be submitted or
Current Credentialing Address	N	ew Credentialing Address
Address Line 1:	Ad	ddress Line 1:
Address Line 2:	Ad	ddress Line 2:
City:	Ci	ty:
State: Zip Code:	St	ate: Zip Code:
Telephone Number: Ext:	Te	elephone Number: Ext:
Numeric digits only. Numeric digits only.	N	umeric digits only. Numeric digits only.
Email:	Er	nail:
you@example.com	<u>yc</u>	bu@example.com
Fax Number: Numeric digits only. For example: 1234567890	Fa	ax Number: umeric digits only.
Credentialing Contact Name:		
Additional Information Comments:	* Effective Date of Char	nge: Attach Documentation: Note: combined file sizes cannot exceed 25MB. File formats
		accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .bd, .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

Administrative Address:

Changes requested to a group's information will o the group letterhead.	ly be accepted if submitted by the group. Supp	
	ny be accepted it submitted by the group. Suppo	orting documentation must be submitted
Current Administrative Address	New Administrative Addre	ess
Address Line 1:	Address Line 1:	
Address Line 2:	Address Line 2:	
City:	City:	
State: Zip Code:	State: Zip Code:	
Telephone Number: Ext: Numeric digits only. Numeric digits only.	Telephone Number: Ext: Numeric digits only. Num	neric digits only.
Email:	Email:	
you@example.com	you@example.com	
Fax Number:	Fax Number:	a. 1234567890
Administrative Contact Name:		
Additional Information Comments:	Effective Date of Change: Attach Docum Note: combined accepted: .bmp, .xdsx. User can s	nentation: file sizes cannot exceed 25MB. File formats .doc, .docx, .gif, jpeg, jpg, zip, .pdf, .png, .bt, .x select only up to 5 total files per request type.
	Combined file Choose File	e size = 0.0 MB No file chosen file
Back		Submit Form

Other Provider Updates:

* Indicates required field	
Current Information	New Information
Hospital Privilege (list all):	Hospital Privilege (list all):
Ambulatory Surgery Center Privileges (list all):	Ambulatory Surgery Center Privileges (list all):
License Number:	License Number:
Specialty:	Specialty:
Subspecialty:	Subspecialty:
Specialty Effective Date:	Specialty Effective Date:
Specialty Certification Date:	Specialty Certification Date:
Board Certified: O Yes O No	Board Certified: O Yes O No
Provide Lactation Services: O Yes O No	Provide Lactation Services: O Yes O No
	Date Of Birth:
	DEA Number
	DEA Number Expiration Date:
	Medical School Name:
	Date of Graduation:
	Residency Hospital Name:
	Residency Period:
	From 🛍 To
	Ethnicity:
Additional Information	
Comments: * Effective E	Date of Change: Attach Documentation:
	Note: combined me sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .bt, .xls, .view. Llogr can polect only us to E. Istali Flow as request the
	Combined file size = 0.0 MB
	Choose File No file chosen + Add another file

Remove Provider f	rom Group/Locatio	n:
Remove Pro * Indicates required	vider from Group/Loca	tion
If you are removin	ng a provider from more than tw	vo service locations, please Attach an Excel file with all applicable locations.
Individual Provi	der Information	
* Individual Provid	Jer Name:	
Individual's Type	1 NPI:	
Other ID Number	(Eg: Medicaid #, API #, LTSS #	ŧ, TPI #):
Provider Locatio	n Information	
Remove Prov	rider from all locations on file	
Address Line 1:		
Address Line 2:		
City:		
State: Zip C	ode:	
* Reason for leav	ing:	•
* Effective Date o	f Termination:	
Add another	ocation for removal	
Additional In Comments:	formation	Attach Documentation:
		Note: Combined file sizes cannot exceed 25MB. Hie formats accepted. Joing, doc, docx, dir, jpeg, jpg, zap, par, .png, bd, xis, xisx. 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	in this form is accurate and complete.
Back		Submit Form