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 How to Update Your Information from the list of options.

4. Scroll to Demographic Changes, then 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

<table>
<thead>
<tr>
<th>Submitter Information</th>
<th>Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>* First Name:</td>
<td>* Name of Provider/Group:</td>
</tr>
<tr>
<td></td>
<td>* Tax ID Number:</td>
</tr>
<tr>
<td>* Last Name:</td>
<td>Rendering NPI:</td>
</tr>
<tr>
<td></td>
<td>* Billing NPI Number:</td>
</tr>
<tr>
<td>* Telephone Number:Ext:</td>
<td>Numeric digits only</td>
</tr>
<tr>
<td></td>
<td>Numeric digits only</td>
</tr>
<tr>
<td>* Job Title/Position:</td>
<td>* Type:</td>
</tr>
<tr>
<td>* Email Address:</td>
<td><a href="mailto:you@example.com">you@example.com</a></td>
</tr>
</tbody>
</table>


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 fulfills 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
   o Daytime Telephone Number
   o Job Title/Position
   o 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.
      o 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.
      o 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:

![Change Existing Demographic Information](image)

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

![Change Existing Demographic Information](image)
Next Screenshots are in chronological order based on the Type of Change selected in the previous screenshot

Name:

### Change Existing Demographic Information

#### Name Change
* Indicates required field

Attach signed and dated W-9 for name change. If you have multiple titles please list additional titles in the below comments box.

<table>
<thead>
<tr>
<th>Current Name</th>
<th>New Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>First Name:</td>
</tr>
<tr>
<td>Middle Name:</td>
<td>Middle Name:</td>
</tr>
<tr>
<td>Last Name:</td>
<td>Last Name:</td>
</tr>
<tr>
<td>Suffix:</td>
<td>Suffix:</td>
</tr>
<tr>
<td>Current Title:</td>
<td>New Title:</td>
</tr>
<tr>
<td>Current Practice Name:</td>
<td>New Practice Name:</td>
</tr>
</tbody>
</table>

#### 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, .pdf, .png, .txt, .xlsx. User can select only up to 5 total files per request type.

**Combined file size = 0.0 MB**

<table>
<thead>
<tr>
<th>Choose File</th>
<th>No file chosen</th>
</tr>
</thead>
</table>
| + Add another file

Back | Submit Form

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Change Existing Demographic Information

NPI/Tax ID Change
* Indicates required field

Attach signed and dated W-9 with correct classification box checked.

Current Information

Current Billing NPI Number: 

Current Tax ID Number: 

New Information

New Billing NPI Number: 

New Tax ID Number: 

Additional Information

Comments: 

* Effective Date of Change: 

Attach Documentation:
Notes: combined file size cannot exceed 25MB. File formats accepted: bmp, doc, docx, gif, jpeg, jpg, zip, pdf, png, txt, xls. 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.

<table>
<thead>
<tr>
<th>Current Office Physical Address</th>
<th>New Office Physical Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address Line 1</td>
<td>Address Line 1</td>
</tr>
<tr>
<td>Address Line 2</td>
<td>Address Line 2</td>
</tr>
<tr>
<td>City</td>
<td>City</td>
</tr>
<tr>
<td>State</td>
<td>State</td>
</tr>
<tr>
<td>Zip Code</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Telephone Number</td>
<td>Telephone Number</td>
</tr>
<tr>
<td>Fax Number</td>
<td>Fax Number</td>
</tr>
<tr>
<td>Email</td>
<td>Email</td>
</tr>
<tr>
<td>Supervising Physician</td>
<td></td>
</tr>
<tr>
<td>Accepting New Patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- Site Accessible
- Parking Accessibility
- Exterior Building
- Interior Building
- Exam Room
- Exam Table
- Office Reception Area
- Close Proximity to Public Transportation

Treating Categories

* Does the provider treat the following?

- Homebound
- Homeless
- Blindness or Visually Impaired
- Chronic Illness
- Serious Mental Illness
- Go accounting Disorders
- HIV/AIDS
- Physical Disabilities
- Osteoporosis/Handicapped

Additional Information

Comments

Effective Date of Change

Attach Documentation (Note: Combined file size cannot exceed 25MB. File formats accepted are doc, docx, pdf, png, jpg, zip, pdf, zip, all, etc. File can select only up to 10 files per required type. Combined file size = 6.0 MB)

Choose File  No file chosen
  Add another file
Demographic Change Form User Guide

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, .pdf, .png, .txt, .xls, .xlsx. User can select 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
## 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.

<table>
<thead>
<tr>
<th>Current Credentialing Address</th>
<th>New Credentialing Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address Line 1:</td>
<td>Address Line 1:</td>
</tr>
<tr>
<td>Address Line 2:</td>
<td>Address Line 2:</td>
</tr>
<tr>
<td>City:</td>
<td>City:</td>
</tr>
<tr>
<td>State: Zip Code:</td>
<td>State: Zip Code:</td>
</tr>
<tr>
<td>Telephone Number: Ext:</td>
<td>Telephone Number: Ext:</td>
</tr>
<tr>
<td>Email:</td>
<td>Email:</td>
</tr>
<tr>
<td>Fax Number:</td>
<td>Fax Number:</td>
</tr>
<tr>
<td>Credentialing Contact Name:</td>
<td></td>
</tr>
</tbody>
</table>

**Additional Information**

Comments:

* Effective Date of Change:

Attach Documentation:

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

- Combined file size = 0.0 MB
- Add another file

---

Back  Submit Form

Powered by Salesforce™
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: 

Email: you@example.com 

Fax Number: 

Numeric digits only. For example: 1234567890 

New Administrative Address

Address Line 1: 

Address Line 2: 

City: 

State: Zip Code: 

Telephone Number: Ext: 

Email: you@example.com 

Fax Number: 

Numeric digits only. For example: 1234567890 

Administrative Contact 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, png, pdf, png, txt, xla. 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

**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 size cannot exceed 25MB. File formats accepted: .txt, .doc, .docx, .pdf, .jpg, .jpeg, .png, .xls, .xlsx. User can select up to 5 total files per request type.

Combined file size: 0.0 MB
- Choose File
- No file chosen
- [ ] Add another file
Remove Provider from Group/Location:

<table>
<thead>
<tr>
<th>Remove Provider from Group/Location</th>
<th>* Indicates required field</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Provider Information</strong></td>
<td></td>
</tr>
<tr>
<td>* Individual Provider Name:</td>
<td></td>
</tr>
<tr>
<td>Individual's Type 1 NPI:</td>
<td></td>
</tr>
<tr>
<td>Other ID Number (Eg. Medicaid #, API #, LTSS #, TPI #):</td>
<td></td>
</tr>
<tr>
<td><strong>Provider Location Information</strong></td>
<td></td>
</tr>
<tr>
<td>Remove Provider from all locations on file</td>
<td></td>
</tr>
<tr>
<td>Address Line 1:</td>
<td></td>
</tr>
<tr>
<td>Address Line 2:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td></td>
</tr>
<tr>
<td>State:    Zip Code:</td>
<td></td>
</tr>
<tr>
<td>* Reason for leaving:</td>
<td></td>
</tr>
<tr>
<td>* Effective Date of Termination:</td>
<td></td>
</tr>
<tr>
<td>Add another location for removal</td>
<td></td>
</tr>
</tbody>
</table>

**Additional Information**

Comments: 

Attach Documentation:
- Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .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