Use the Provider Change Form to Keep Your Data Current

Correct Information Prevents Delays in Claims Payments

It is vital that you notify Blue Cross and Blue Shield of Texas (BCBSTX) and the Texas Medicaid & Healthcare Partnership (TMHP) any time there are changes to your information, (i.e. Tax ID Number, phone number, address, new services are made available, etc.)

Timely notification of changes is part of your contractual agreement with us and the state. In addition, these updates keep our records current, and can help you avoid delays in claims payments.

Updating your information is fast and easy.

- TAX ID or Termination Request – Contracted providers or groups requesting a Tax ID change or termination from a provider network please contact your Network Management Consultant directly.
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- Providers needing to update demographic information on an existing record should complete and submit the Provider Data Update Notification Form.

How to Access to the BCBSTX Provider Data Update Notification Form

1. Go to **www.bcbstx.com.**
2. Select **Providers** at the top of the page.
3. Select **Network Participation**
4. Select **Update Your Information**

For the TMHP Provider Information Change Form, refer to the instructions that accompany the form

How to Access the Texas Medicaid & Healthcare Partnership Provider Information Change Form

1. Go to www.tmhp.com.
2. Click on **Providers**, then click on **Forms.**
3. Under Provider Enrollment, click on **Provider Information Change Form.**

Representations of both forms are illustrated below for your reference. Obtain the actual forms through the directions above. Instructions appear on both of the forms.

For More Information

If you have questions about the provider information that we currently have on file for you, please contact your Customer Care Center at **1-877-560-8055.**

Provider Data Update Notification Form

If requesting termination from a Provider Network, please contact your Local Network Management.

* Indicates a required field

Name of Provider/Group: *

NPI Number: * * Type 1: Type 2:

Tax ID Number:

Please Select All Categories That Apply and Attach Applicable Documentation:

- Name Change

  Note: If this change is for a Group, attach signed and dated W9

- Office Address/Telephone/Fax Change

  Note: If your primary address change involves moving to a different county, this could impact your claims payment. This information is utilized for the member directories a P.O. Box will not be accepted as an office address.

- Payee Address/Telephone Change

  Note: Changes requested to a Group's information will only be accepted if submitted by the Group. Supporting documentation must be submitted on group Letter head.

- E-mail Address Change
- Ethnicity (optional)
- Other Change

  Note: If unable to upload needed documentation, please submit your request with supporting documents via fax at 972-231-9664 or mail to: P.O. Box 650267 Dallas, Tx 75265-0267.

Name of Submitter: *

Title: *

Phone: *

Attach documents: Choose File No file chosen

Submit

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Provider Information Change Form

Texas Medicaid fee-for-service, Children with Special Health Care Needs (CSHCN) Services Program, and Primary Care Case Management (PCCM) providers can complete and submit this form to update their provider enrollment file. Print or type all of the information on this form. Mail or fax the completed form and any additional documentation to the address at the bottom of the page.

Check the box to indicate a PCCM Provider ☐	Date : / /
Nine-Digit Texas Provider Identifier (TPI):	Provider Name:
National Provider Identifier (NPI):	Primary Taxonomy Code:
Atypical Provider Identifier (API):	Benefit Code:

List any additional TPIs that use the same provider information:

TPI:	TPI:	TPI:
TPI:	TPI:	TPI:
TPI:	TPI:	TPI:

Physical Address—The physical address cannot be a PO Box. Ambulatory Surgical Centers enrolled with Traditional Medicaid who change their ZIP Code must submit a copy of the Medicare letter along with this form.

Street address	City	County	State	Zip Code
Telephone: ( )	Fax Number: ( )	Email:		

Accounting/Mailing Address—All providers who make changes to the Accounting/Mailing address must submit a copy of the W-9 Form along with this form.

Street Address	City	State	Zip Code
Telephone: ( )	Fax Number: ( )	Email:	

Secondary Address

Street Address	City	State	Zip Code
Telephone: ( )	Fax Number: ( )	Email:	

Type of Change (check the appropriate box)

☐	Change of physical address, telephone, and/or fax number
☐	Change of billing/mailing address, telephone, and/or fax number
☐	Change/add secondary address, telephone, and/or fax number
☐	Change of provider status (e.g., termination from plan, moved out of area, specialist) *Explain in the Comments field*
☐	Other (e.g., panel closing, capacity changes, and age acceptance)

Comments:

Tax Information—Tax Identification (ID) Number and Name for the Internal Revenue Service (IRS)

Tax ID number:	Effective Date:
Exact name reported to the IRS for this Tax ID:	

Provider Demographic Information—Note: This information can be updated on www.tmhp.com.

Languages spoken other than English:	
Provider office hours by location:	
Accepting new clients by program (check one): Accepting new clients ☐ Current clients only ☐ No ☐	
Patient age range accepted by provider:	Additional services offered (check one): HIV ☐ High Risk OB ☐ Hearing Services for Children ☐
Participation in the Woman's Health Program? Yes ☐ No ☐	Patient gender limitations: Female ☐ Male ☐ Both ☐

Signature and date are *required* or the form will *not* be processed.

Provider signature:	Date: / /
Mail or fax the completed form to: Texas Medicaid & Healthcare Partnership (TMHP)	Fax: 512-514-4214

Effective Date_01012009/Revised Date_01212010