



Check Your Data



How to use our Demographic Change Form to verify directory information

Federal law requires that certain [directory information be verified every 90 days](#), and that we remove you from our provider directory, [Provider Finder](#)[®], if it isn't.

Professional Providers

Professional providers **have two options to verify their data** every 90 days:

- [Availity[®] Essentials](#) Provider Data Management ([PDM](#)) [feature](#), which we recommend as a quick way to verify information with us and other insurers, or
- Our online [Demographic Change Form](#) , which can be found on the [Verify and Update Your Information page](#) on our Provider website.

Follow the steps in this guide to verify your data using the Demographic Change Form. **Groups with multiple providers** must submit the form for each provider in the group per location. Use the Google Chrome browser for best results.

If you need to change your data:

- You **may continue to use the [Demographic Change Form](#)** to update your data. When updating, complete all relevant and required fields on the form.
- Some data can be updated through the Availity [PDM feature](#).

If you update your information, **it will count as your 90-day verification**.

Facilities and Ancillary Providers

The [Demographic Change Form](#) is the only way for facilities and ancillary providers to verify and update data.

We won't accept demographic changes by email, phone or fax to enable us to meet the two-day directory update requirement defined by federal law.



Instructions for Professional Providers, Facilities and Ancillary Providers

To verify information using the Demographic Change Form

1. Fill in **required fields** on the first page to start the verification process.

Select **Individual Provider**, **Group/Clinic** or **Facility/Ancillary**, as appropriate and enter required information.

- If submitting for an Individual Provider, select **Type 1 NPI**.
- If submitting for Group/Clinic or Facility/Ancillary, select **Type 2 NPI**.

Select **Next** when complete.

Change Existing Demographic Information

Identification Information
* Indicates required field

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

<p>Submitter Information</p> <p>* First Name: _____</p> <p>* Last Name: _____</p> <p>* Telephone Number: Ext: _____ <small>Numeric digits only Numeric digits only.</small></p> <p>* Job Title/Position: _____</p> <p>* Email Address: _____ <small>you@example.com</small></p>	<p>Provider Information</p> <p>* Name of Provider/Group: _____</p> <p>* Tax ID Number: _____</p> <p>Rendering NPI: _____</p> <p>* Billing NPI Number: _____</p> <p>* Type <input type="radio"/> Type 1 (Individual) <input type="radio"/> Type 2 (Group)</p>
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2. Select **Name**, **Office Physical Address** and **Other Provider Updates** to see the information that must be verified.

If you are verifying multiple locations:

- You must submit the form for each location.
- Select **Name**, **Office Physical Address** and **Other Provider Updates** for your first submission.
- For your next submissions, you won't need to select **Name** or **Other Provider Updates**.

When complete, select **Next**.

Change Existing Demographic Information

Type of Change

Name

NPI/Tax

Office Physical Address

Billing Address

Credentialing Address

Administrative Address

Other Provider Updates

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3. Verify name.

Individual Providers: Fill in the **Name** fields.

Group/Clinic or Facility/Ancillary: Fill in **Current Practice Name**.

For **Effective Date of Change**:

- When **verifying data**, fill in **today's date**.
- When **changing data**, fill in **date of change**.

Select **Next** when complete.

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.

<p>Current Name</p> <div style="border: 1px solid #0070c0; padding: 5px; margin-bottom: 5px;"><p>First Name: Individual Provider</p><hr/><p>Middle Name</p><hr/><p>Last Name:</p><hr/><p>Suffix: ▼</p></div> <p>Current Title:</p> <hr/> <div style="border: 1px solid #0070c0; padding: 5px; margin-bottom: 5px;"><p>Current Practice Name: Group/Clinic/Facility/Ancillary</p></div>	<p>New Name</p> <p>First Name:</p> <hr/> <p>Middle Name:</p> <hr/> <p>Last Name:</p> <hr/> <p>Suffix: ▼</p> <p>New Title:</p> <hr/> <p>New Practice Name:</p> <hr/>
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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

No file chosen

Add another file



4. Verify office physical address.

Fill in the office **Address, City, State, ZIP code, Telephone Number** and **Email**.

Fill in today's date for **Effective Date of Change** if you're verifying information.

Select **Next** when complete.

Change Existing Demographic Information

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.

<p>Current Office Physical Address</p> <p>Address Line 1: _____</p> <p>Address Line 2: _____</p> <p>City: _____</p> <p>State: Zip Code: _____</p> <p>Telephone Number: Ext: <small>Numeric digits only.</small> <small>Numeric digits only.</small></p> <p>Email: <i>you@example.com</i></p> <p>Fax Number: <small>Numeric digits only. For example: 1234567890</small></p>	<p>New Office Physical Address</p> <p>Address Line 1: _____</p> <p>Address Line 2: _____</p> <p>City: _____</p> <p>State: Zip Code: _____</p> <p>Telephone Number: Ext: <small>Numeric digits only.</small> <small>Numeric digits only.</small></p> <p>Email: <i>you@example.com</i></p> <p>Fax Number: <small>Numeric digits only. For example: 1234567890</small></p>
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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

No file chosen

Add another file

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5. Verify specialty and submit form.

Under **Other Provider Updates**, fill in **Specialty**. It is the only data in this section that must be verified.

If verifying information, fill in today's date for **Effective Date of Change**.

When complete, select **Submit Form**.

You will receive a case number confirming you've verified or changed your data after you submit the form.

Change Existing Demographic Information

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: <input type="radio"/> Yes <input type="radio"/> No	Board Certified: <input type="radio"/> Yes <input type="radio"/> No
Provide Lactation Services: <input type="radio"/> Yes <input type="radio"/> No	Provide Lactation Services: <input type="radio"/> Yes <input type="radio"/> No
Medication Assisted Treatment	Date Of Birth: _____
Is Medication Assisted Treatment for Opioid Use Disorders provided at this location?	Languages (spoken or written): _____
<input type="radio"/> Yes <input type="radio"/> No	
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 <input type="button" value="Choose File"/> No file chosen <input type="button" value="+ Add another file"/>
* <input type="checkbox"/> Provider/ Group has reviewed the information listed on the BCBSIL provider finder for accuracy and is hereby attesting that all other information is accurate.	
<input type="button" value="Back"/>	<input type="button" value="Submit Form"/>

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