PLEASE PRINT OR TYPE ALL INFORMATION
YOU MUST INCLUDE COPIES OF YOUR CURRENT IRS W-9 FORM AND
STATE LICENSE WITH THE INFORMATION SHOWN BELOW

PRACTITIONER **MUST BE COMPLETED BY ALL INDIVIDUAL PRACTITIONERS**		
Provider Name: _____ **(Last) (First) (MI)**		
Provider type (i.e., MD, DO, DDS, DC)		
Provider specialty (i.e., Family Practice, Internal Med, OB/GYN):		
License No. (copy required): **Effective date of license:**		
State issued by: **Practitioner Medicare B #:**		
SSN: **DOB: / /**	**NPI #**	**Gender:** ☐ **M** ☐ **F**
Taxonomy:	**Effective Date: (required)**	

GROUP **MUST BE COMPLETED BY ALL PROVIDERS**	
Legal Name of Group (for 1099 reporting):	
TAX ID # (for 1099 reporting W-9 required):	
Group DBA Name:	
Group NPI: (if billed on claim)	
Group Medicare B#:	
Primary Practice Address	**Secondary Practice Address**
Street:	**Street:**
City, St, ZIP:	**City, St, ZIP:**
Telephone No. ( )	**Telephone No. ( )**
FAX No. ( )	**FAX No. ( )**
Remittance Address	**TAX Address** (if different)
Street:	**Street:**
City, St, ZIP:	**City, St, ZIP:**

- All providers will be loaded as Non-Participating until credentialed and contracted. If you would like to be a Network Participating Provider(requires credentialing), then please visit Providers.BlueKC.com and click on "Joining the Blue KC Network?" option. For Behavioral Health providers, please visit NDBH.com. Email the completed form to Provider_Data@BlueKC.com or fax to 816-395-3387.

Form Completed by: _____ **Date:** _____		
Email:	**Phone Number:**	**Fax Number:**