Kansas City

PROVIDER DEMOGRAPHIC CHANGE FORM

Instructions: Advance notice is required for name or address change, notice of retirement, or other changes relating to your practice. When adding, changing or removing a location with multiple individual providers, you may attach a list with this form. A separate form is not required for each provider. **Please type and complete all required sections.**

I. FILL OUT GENERAL INFORMATION (REQUIRED)

Group or Practice Name _____ Organization NPI _____

Group or Practice Tax ID (EIN/SSN)_____ Blue KC Provider ID _____

Are you currently contracted with Blue KC? ☐ Yes ☐ No

Name of Individual Completing Form _____ *(Required)*

Phone (____)_____ Email _____ *(Required)*

II. SELECT REASON (S) FOR SUBMITTING FORM (REQUIRED)

Change Applies to **Entire Practice / Group**	Change Applies to **Specific Practice / Group Location(s)**	Change Applies to an **Individual Practitioner(s)**
☐ Change Practice Name	☐ Add a new Practice Location	☐ Add a new Practitioner to Group
☐ Change of Ownership, Tax ID or Organization NPI # (Fill out **Section A**)	☐ Remove a Practice Location (Fill out **Section C**)	☐ Remove a Practitioner from Group
		☐ Update an Existing Practitioner (Fill out **Section D**)
☐ Change Remittance Advice (Remit) / Billing Address (Fill out **Section B**)	☐ Make changes to an Existing Practice Address (Fill out **Section B**)	

Clarify Request. Briefly describe the reason for submitting this form:

SECTION A: UPDATE EXISTING ADDRESS INFORMATION

This change applies to: ☐ Practice Address ☐ Remit/Billing Address ☐ Both Practice & Remit/Billing Address

Effective Date of Change: _____ / _____ / _____ (**CANNOT** be Retroactive)

NEW INFORMATION		**PREVIOUS INFORMATION**	
Street (incl. Suite):		Street (incl. Suite):	
City:		City:	
State:	Zip:	State:	Zip:
Phone: (____)_____	Fax: (____)_____	Phone: (____)_____	Fax: (____)_____

Handicap Accessible Location? ☐ Yes ☐ No

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SECTION B: ☐ ADD ☐ REMOVE PRACTICE LOCATIONS FROM ENTIRE GROUP

Effective Date of Change: _____ / _____ / _____ (**CANNOT** be Retroactive)

ADD	TERM	PRACTICE ADDRESS (INCLUDE SUITE # / BLDG. #)	CITY	STATE	ZIP	PHONE	FAX	APPLY THIS CHANGE TO **ALL** PRACTITIONERS?
☐	☐							
☐	☐							
☐	☐							

SECTION C: ☐ ADD ☐ REMOVE ☐ UPDATE PRACTITIONER INFORMATION

FILL IN COMPLETELY.

Provider Name _____

☐ Check box if this is a name change.

Submit proof of name change with this form (i.e. Copy of Driver, Professional, or Marriage License; Court Order; SSN card)

Individual NPI # _____

Note: This form should not be submitted for providers who have not yet been credentialed by Blue KC. If you are unsure of your provider's credentialing status, contact your External Provider Representative for assistance.

☐ Primary Care Physician ☐ Specialist

- List Specialty _____

Accepting New Patients?

☐ Mid-Level

- Sponsoring Physician Name _____
- Sponsoring Physician NPI# _____

☐ Other (Describe) _____

Licensed in: ☐ MO: _____ ☐ KS: _____

Accepts Medicare? ☐ Yes ☐ No

Accepts Medicaid? ☐ Yes ☐ No

☐ ASSIGN A PRACTITIONER TO PRACTICE LOCATIONS

Effective Date of Change: _____ / _____ / _____ (**CANNOT** be Retroactive)

☐ Assign practitioner to **all** practice locations (new to practice)

☐ Assign to the following practice locations **only**:

GROUP ID#	PRACTICE ADDRESS

☐ REMOVE PRACTITIONER FROM PRACTICE LOCATIONS

Effective Date of Change: _____ / _____ / _____ (**CANNOT** be Retroactive)

If PCP, move members/patients to the following physician: _____

☐ Remove practitioner from **all** practice locations

Select Reason for Leaving:

☐ Remove from the following practice locations **only**:

GROUP ID#	PRACTICE ADDRESS

Upon **Completion,** click the **Submit Form** button below. A prepopulated email with this form as an attachment will appear. Attach all required documents. Include your own email address as a 'cc' for the email. Click the email 'send' button to submit form.

If you are unable to use the online submission process, complete the form then click the **Print Form** button below. It is important to print a copy of the completed form prior to closing the file, otherwise all entered information will be lost. Fax the form and any required documents to **816-395-3387**.

Print Form

Submit Form