

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: <input type="checkbox"/> M <input type="checkbox"/> 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#:	
<u>Primary Practice Address</u>	<u>Secondary Practice Address</u>
Street:	Street:
City, St, ZIP:	City, St, ZIP:
Telephone No. ()	Telephone No. ()
FAX No. ()	FAX No. ()
<u>Remittance Address</u>	<u>TAX Address</u> (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. Fax to 816-395-3387.

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