PREMERA BLUE CROSS

Premera Blue Cross
P.O. Box 327, MS 453
Seattle, WA 98111-0327

Practitioner Data Sheet

The following information is required for OIC and internal reporting.

Practitioner Name: ____, ____________
(Last Name) (First Name) (MI) (Credential based on licensure)

Social Security #: ____________________ **DOB:** _____________ ☐ **Male** ☐ **Female**

State License #: _____________________________ **State:**_________

Additional State License #: _________________________ **State:**_________

DSHS #: _________ **UPIN #:**____________ **DEA #:**_____________ (if applicable) **Medicare #:** __________

Individual NPI #: ______________________________

Foreign Languages Spoken: ____

Specialty(s):

1)___________________________________ (Primary Specialty) **Board Status:** ☐ **N/A** ☐ **Board Certified** ☐**Board Eligible** (check one. If other, please explain)

2)___________________________________ (Secondary Specialty) **Board Status:** ☐ **N/A** ☐ **Board Certified** ☐**Board Eligible** (check one. If other, please explain)

Clinic/Group Name: ____

Group NPI #: ______________________________

Start Date at Clinic/Group: ____________________________

Primary practice address: ____
(Street Address - City – State – Zip Code)

Services available: ☐ **Wheelchair Accessible?** ☐ **Interpretive Services?**

Tax ID#:_________________________ **Office Hours:**____________________________________

Phone (_____)______________________ **Phone - Fax (_____)**______________________

Pay to Address: ____

Mailing Address: (ie., correspondence) ____

E-mail address (clinic): ___________________ **E-mail address (practitioner):** ____________________

If more than one practice location, please attach list and provide the same information for each location.

Form completed by:____ **Date:**_____________

014664 (12-2005)
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