Premera | 🚭

BLUE CROSS

Instructions

Provider Update

- Use this form to update your practice information and keep our provider directory current.
- To see your current listing, view the <u>Provider Directory.</u>
- Send the completed form to <u>Provider.Relations@Premera.com</u> or fax: 425-918-4937.

A. General information (required)

Requestor's name	Practice name
Requestor's email address	Tax ID/ EIN
Requestor's phone – include area code	Include a copy of current SS4/147C with this form.

B. Address changes

D. Audiess chang	162						
Action requested. Select one.				Effective date of change (required)			
O Moving locations							
• Adding new location. Must complete Section B and C below.				n B and C below.			
If moving, previous	location ac	ldress. This ad	dress	will be removed.			
New location addre	ss. This m	ust be a physic	al loca	ation. It cannot be a	PO Box or Private Ma	nilbox.	
Street address							
City	ty State ZIP code		ZIP code				
New location phone – include area code			New	location fax - inclue	New location group NPI		
New location name	for the dire	ectory					
Telehealth/virtual ca	are						
O In-office only							
O Telehealth onlyO Both	/ (address	will be hidder	n from	n online directory)			
Remit/Pay to Address:	Select one O Same	as new locatio	on C	Separate address	s, complete below		
Street address or PO	Box						
City		State		ZIP code	Pay to name		
	Select one			·			
Mailing Address:		as new locatio	on C	Same as remit	O Separate addres	s, complete below	
Street address or PO	Box						
City		State		ZIP code			

Credentialing Address:	Select one. O Same as new location O Same as remit O Separate address, complete below						
Street address or	PO Box						
City	State	ZIP code	Credentialing email				
	ctitioners at new locatio	n. Attach additio	nal sheets as needed.				
Effective date of	change (required)						
Practitioner full	name	NPI	Specialty				

D. Add new practitioner to an existing location. Attach additional sheets as needed.

Effective date (required)					
Practitioner's full name		NPI		Specialty	
Practitioner's primary location	Practition	er's secondary locatio		'n	Accepting new patients – select one O Yes O No O Established patients only
Select one for each category:					
Primary care provider (PCP?)		O Yes	O No		
List in directory?		O Yes	O No		
Virtual health?		O Yes	O No		
Associate level behavioral health practitioner?		O Yes	O No		

E. Terminations

Requested termination date (required)	Termination reason (required)
Termination type - select one	1
old O Contract, including all locations and $ $	practitioners under the contract
• Location(s). Enter the complete addr	ess(es <i>)</i> .
O Practitioner only - enter full name	NPI
This practitioner will be leaving all lo	cations under this TIN: