PREMERA | BLUE CROSS

PROVIDER UPDATE FORM

Use this form to tell us about any new information or changes to your current practice or payment structure.
You can email this completed form to Provider.RelationsWest@premera.com or fax it to 425-918-4937.
If you have any questions, call Provider Relations at 877-342-5258, option 4.

Fields marked with an asterisk * are required for all changes/updates.

***PROVIDER INFORMATION:**

*Contact name: _____

*Phone: _____

*Email: _____

*Tax ID: _____

***Type of change/update:**

☐Address (any type) ☐New provider/clinic name ☐Phone (any type) ☐Add new location ☐ Specialty ☐Tax ID (W-9 required)

***Effective date of change:** _____

OLD INFORMATION: **Only** complete the fields below where the current information we have on file is changing.

Old clinic name: _____

Old provider name: _____

NPI: _____

Physical location address:

Street address : _____

Suite number: _____

City: _____ State: _____ ZIP: _____

Phone number: _____ **Fax number:** _____

Specialty: _____ _____ _____

Remit/payable to address:

Street address: _____

Suite number: _____

City: _____ State: _____ ZIP: _____

Mailing address:

Street address: _____

Suite number: _____

City: _____ State: _____ ZIP: _____

Credentialing address:

Street address: _____

Suite number: _____

City: _____ State: _____ ZIP: _____

Phone number: _____ **Fax number:** _____

NEW INFORMATION: Complete the fields below with your updated information.

New clinic name: _____

New provider name: _____

Tax ID: _____

NPI: _____

New demographics apply to the following types of addresses: (check each one that applies).

☐ Physical Address ☐ Mailing ☐ Remit/Payable ☐ Credentialing

Street address: _____

Suite number: _____

City: _____ State: _____ ZIP: _____

Phone number: _____ **Fax number:** _____

Specialty: _____ _____ _____

Other address (please explain in comments):

Street address: _____

Suite number: _____

City: _____ State: _____ ZIP: _____

Phone number: _____ **Fax number:** _____

Comments: _____

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