



**BLUE CROSS BLUE SHIELD OF ALASKA**

# PROVIDER UPDATE FORM

Use this form to update your practice information and keep our provider directory current.  
Send the completed form by email at [provider.relationships@premera.com](mailto:provider.relationships@premera.com) or fax: 425-918-4937.  
Check out our self-service tools at [premera.com/ak/provider/](http://premera.com/ak/provider/).

## GENERAL INFORMATION

Practice name: \_\_\_\_\_  
Practice tax ID/EIN: \_\_\_\_\_  
Organization NPI: \_\_\_\_\_  
Credentialing email: \_\_\_\_\_  
Primary office email: \_\_\_\_\_

Name of individual completing form: \_\_\_\_\_  
Individual's phone number: \_\_\_\_\_  
Individual's email: \_\_\_\_\_

## UPDATE TYPE (check all that apply)

Change Applies to Entire Practice/Group	Change Applies to Specific Practice or Group Location(s)	Change Applies to Individual Provider(s)
<input type="checkbox"/> Change practice name <input type="checkbox"/> Change of ownership, tax ID or organization NPI # <input type="checkbox"/> Change payment/remit address <input type="checkbox"/> Change credentialing address <input type="checkbox"/> Change communications address	<input type="checkbox"/> Make changes to an existing location address <input type="checkbox"/> Add a new practice location <input type="checkbox"/> Remove a practice location	<input type="checkbox"/> Add or remove a practitioner <input type="checkbox"/> Update an existing practitioner

Other (please specify the reason for submitting this form): \_\_\_\_\_

Effective date of change: \_\_\_/\_\_\_/\_\_\_

## CHANGE OF PRACTICE NAME/OWNERSHIP/TAX ID CHANGE

Change Practice Name

New name: \_\_\_\_\_

Previous name: \_\_\_\_\_

Change of Ownership/Tax ID\*

**\*Must submit a copy of the IRS SS-4 confirmation letter with this form.**

New tax ID: \_\_\_\_\_

Previous tax ID: \_\_\_\_\_

New NPI: \_\_\_\_\_

Previous NPI: \_\_\_\_\_

## UPDATE EXISTING ADDRESS INFORMATION

Change applies to (check all that apply):  Location  Payment  Credentialing  Communication

### NEW INFORMATION:

Street (include suite/building #)  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### PREVIOUS INFORMATION:

Street (include suite/building #)  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**ADD OR TERM PRACTICE LOCATION(S) FROM ENTIRE GROUP**

ADD	TERM	CLINIC NAME OR DBA PRACTICE ADDRESS (INCLUDE SUITE/BUILDING #)	CITY	STATE	ZIP	PHONE	FAX
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						

List practitioners with NPI to be added to above locations. If more space is needed, attach additional information.

**NAME/NPI**

**NAME/NPI**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ADD/REMOVE/UPDATE PRACTITIONER INFORMATION**

To credential a new provider, see [premera.com/ak/provider/reference/join-our-network/](http://premera.com/ak/provider/reference/join-our-network/).

Provider name: \_\_\_\_\_

Provider NPI: \_\_\_\_\_

List specialty if applicable (not licensure):  
\_\_\_\_\_

Primary care (Y/N): \_\_\_\_\_

List in directory (Y/N): \_\_\_\_\_

Virtual health (Y/N): \_\_\_\_\_

Accepting new patients:

Yes       No       Established only

**Add Practitioner to Practice Location(s)**

**Remove Practitioner from Practice Location(s)**

Assign practitioner to up to 5 locations (new to practice)

Remove practitioner from all practice locations  
Reason for leaving: \_\_\_\_\_

Remove practitioner from the following practice locations:

Practice address (include suite/building #)

Practice address (include suite/building #)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_