PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Provider Update

Instructions

- Use this form to update your practice information and keep our provider directory current.
- To see your current listing, view the Provider Directory.
- Send the completed form to Provider.Relations@Premera.com 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

Action requested. Select one. ❍ Moving locations ❍ Adding new location. Must complete Section B and C below.			Effective date of change (**required**)
If moving, previous location address. This address will be removed.			
New location address. This must be a physical location. It cannot be a PO Box or Private Mailbox.			
Street address			
City	State	ZIP code	
New location phone – include area code	New location fax – include area code		New location group NPI
New location name for the directory			
Telehealth/virtual care ❍ In-office only ❍ Telehealth only (address will be hidden from online directory) ❍ Both			
Remit/Pay to Address:	Select one. ❍ Same as new location ❍ Separate address, complete below		
Street address or PO Box			
City	State	ZIP code	Pay to name
Communication Mailing Address:	Select one. ❍ Same as new location ❍ Same as remit ❍ Separate address, complete below		
Street address or PO Box			
City	State	ZIP code	

Credentialing Address:	Select one. ❍ Same as new location ❍ Same as remit ❍ Separate address, complete below		
Street address or PO Box			
City	State	ZIP code	Credentialing email

C. Existing practitioners at new location. Attach additional 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	Practitioner's secondary location	Accepting new patients – select one ❍ Yes ❍ No ❍ Established patients only

Select one for each category:		
Primary care provider (PCP?)	❍ Yes	❍ No
List in directory?	❍ Yes	❍ No
Virtual health?	❍ Yes	❍ No
Associate level behavioral health practitioner?	❍ Yes	❍ No

E. Terminations

Requested termination date (**required**)	Termination reason (**required**)

Termination type - select one

❍ Contract, including all locations and practitioners under the contract

❍ Location(s). Enter the complete address(es).

❍ Practitioner only - enter full name	NPI

This practitioner will be leaving all locations under this TIN:
❍ Yes
❍ No. Specify locations: