DENTAL PROVIDER DEMOGRAPHIC CHANGE FORM

Highmark Blue Cross Blue Shield of Western New York
PROVIDER ENROLLMENT DEPARTMENT
257 West Genesee Street • Buffalo, NY 14202

HIGHMARK WESTERN NEW YORK

CONFIDENTIAL
Please **complete all sections** of this form; reply N.A. if not applicable.
For questions or assistance, please call (716) 887-2054

Fax completed form to (716) 887-8886 or email to Provider_Data_Mgmt@bcbswny.com.
Please include your NPI number in the subject line.

Section I: Demographic Data

Name:

_____ _____ ____
Last First MI

NPI # _____

MEDICARE # _____

Practice Location Name:

_____

Group/Facility Name *(if applicable)*:

_____

Primary Hospital Affiliation & Status:

_____

Title: ☐ DMD ☐ DDS

Ethnic Information (optional): Please fill out the section below. This information can assist in the referral process, as members often request providers with a specific background. The information will not affect your provider status.

☐ American Indian or Alaska Native ☐ African-American
☐ Asian or Pacific Islander ☐ Caucasian ☐ Hispanic

Section II: Data Change Summary

THE PURPOSE OF THIS NOTICE IS: *(please check appropriate boxes below)*

☐ **Adding location** Effective Date _____ Tax ID: _____
Provider's Specialty at Site _____ Secondary Specialty at Site _____
Does provider want to be included in the Directory at this Site? ☐ **Yes** ☐ **No**
Accepting New Patients? ☐ **Yes** ☐ **No**
Can patients schedule an appointment to be seen by this Practitioner at this site? ☐ **Yes** ☐ **No**
Are Services Inpatient Only? ☐ **Yes** ☐ **No** Is this site a Nursing Home? ☐ **Yes** ☐ **No**
Restrictions in Practice (ex: age, diagnostic services only): _____

☐ **Terming Location** Effective Date _____ Which site: _____ Tax ID: _____
Reason: _____

☐ **Address Change Only** Effective Date _____ Tax ID: _____
Applies to: ☐ Physical Address ☐ Remit Address ☐ Correspondence Address

☐ **Tax ID Change:** Effective Date _____ New Tax ID _____ Old Tax ID _____
Is Tax ID Change related to a change in ownership*? ☐ **Yes** ☐ **No**
For tax changes related to changes in ownership, a completed copy of the Disclosure of Ownership and Control form **must be submitted.*

☐ **PCMH updated**
*Recognition e-mail received from NCQA is **required**; Including Recognition Level, Locations, Effective Date/Term Date and Listing of Providers (Name, NPI). ***PLEASE ATTACH TO THIS FORM.*

☐ **Other (please specify):** Effective Date _____ Change_____

Section III: Data Change Detail

Please include **ONLY** the location or information you are updating. Use a separate sheet for multiple changes if necessary.
If the same change applies to multiple providers, complete the update below and attach a list of providers for which the change applies.

NEW INFORMATION Physical Street Address				**OLD INFORMATION** Physical Street Address			
City	State	County	Zip	City	State	County	Zip
Phone: _____ Fax: _____ Email: _____				Phone: _____ Fax: _____ Email: _____			

Accessible? ☐ **Yes** ☐ **No*** (if No, see **Sec IV**)	Tax ID No:	Accessible? ☐ **Yes** ☐ **No**	Tax ID No:
Doctors Hours (exact times) **AM** Mon___-___Tue ___-___ Wed ___-___ Thu ___-___ Fri ___-___ Sat ___-___ Sun ___-___ **PM** Mon___-___Tue ___-___ Wed ___-___ Thu ___-___ Fri ___-___ Sat ___-___ Sun ___-___		**Doctors Hours (exact times)** **AM** Mon___-___ Tue ___-___ Wed ___-___ Thu ___-___ Fri ___-___ Sat ___-___ Sun ___-___ **PM** Mon___-___Tue ___-___Wed ___-___ Thu ___-___ Fri ___-___ Sat ___-___ Sun ___-___	
Office Hours (exact times) **AM** Mon___-___Tue ___-___ Wed ___-___ Thu ___-___ Fri ___-___ Sat ___-___ Sun ___-___ **PM** Mon___-___Tue ___-___ Wed ___-___ Thu ___-___ Fri ___-___ Sat ___-___ Sun ___-___		**Office Hours (exact times)** **AM** Mon___-___Tue ___-___ Wed ___-___ Thu ___-___ Fri ___-___ Sat ___-___ Sun ___-___ **PM** Mon___-___Tue ___-___ Wed ___-___ Thu ___-___ Fri ___-___ Sat ___-___ Sun ___-___	
Languages spoken (by provider in this office):		Languages spoken (by provider in this office):	
Payment Name and Address (if different from above):		**Payment Name and Address (if different from above):**	
Pay To Street Address:		Pay To Street Address:	
City:	State: Zip:	City:	State: Zip:
Billing Service Name: _____ Phone: _____ Fax: _____ Email: _____		Billing Service Name: _____ Phone: _____ Fax: _____ Email: _____	
Provider Group/Facility _____ **Group/Facility NPI#:** _____ **Facility Operating Certificate:** _____ **Permanent Facility Number:** _____		**Provider Group/Facility** _____ **Group/Facility NPI#:** _____ **Facility Operating Certificate:** _____ **Permanent Facility Number:** _____	
Street Address:		Street Address:	
City:	State: Zip:	City:	State: Zip:
Contact Name: Email Address:	Contact Phone:	Contact Name: Email Address:	Contact Phone:
Correspondence to: ☐ Service Site ☐ Group Address ☐ Remit Address ☐ Other _____		Correspondence to: ☐ Service Site ☐ Group Address ☐ Remit Address ☐ Other _____	

Section IV: Wheelchair Accessibility

If office is not wheelchair accessible, please indicate how wheelchair dependent patients are accommodated

☐ Refer to local clinic ☐ Refer to local hospital ☐ Refer to other office or location
☐ Service at member residence ☐ Service member at facility

Section V: On-Call Physician Coverage

Complete if you are a solo practitioner, or if you are in a group practice and have coverage outside of your group

*Must be participating with Highmark Blue Cross Blue Shield of Western New York. In the last column, please indicate if you are on-call for each physician you list as on-call for you. On-call coverage **must** be in the same or similar specialty.*

Name	Specialty	Phone	On-call ☐
Name	Specialty	Phone	On-call ☐
Name	Specialty	Phone	On-call ☐

Name of person completing this form: _____

Contact method for questions regarding this form (phone number or email address): _____

Signature of person completing this form: _____ **Date:** _____