Louisiana

Provider Update Request Form

Complete this form to give Blue Cross and Blue Shield of Louisiana the most current information on your practice. Updates may include changes in address and/or hours of operation. Check the box and complete only the sections with needed changes. Please type or print legibly in black ink.

GENERAL INFORMATION

Provider Last Name	First Name	Middle Initial
Tax ID Number	Provider National Provider Identifier (NPI)	
Clinic Name	Clinic National Provider Identifier (NPI)	
Languages Spoken	☐ Adding Language Spoken *(please specify)*	
Name of Person Completing Form		
Contact Phone Number	Contact Email Address	
Current Specialty		
Changing Specialty? ☐ Yes ☐ No	If yes, please specify **New** Specialty	Are you a primary care provider (PCP)? ☐ Yes ☐ No

☐ **BILLING ADDRESS CHANGE (address for payment registers, reimbursement checks, etc.)**

Former Billing Address		Is this change for the entire group? ☐ Yes ☐ No
City, State and ZIP Code		Phone Number
New Billing Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		Effective Date of Address Change

☐ **MEDICAL RECORDS ADDRESS CHANGE (for medical records request)**

Former Medical Records Address		Is this change for the entire group? ☐ Yes ☐ No
City, State and ZIP Code		Phone Number
New Medical Records Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		Effective Date of Address Change

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CORRESPONDENCE ADDRESS CHANGE (for manuals, newsletters, billing guidelines, medical policies, etc.)

Former Correspondence Address		Is this change for the entire group? ☐ Yes ☐ No
City, State and ZIP Code		Phone Number
New Correspondence Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		Effective Date of Address Change

PHYSICAL ADDRESS CHANGE (must include a copy of your liability insurance showing the new address)

Former Physical Address		
City, State and ZIP Code		Phone Number
New Physical Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		Effective Date of Address Change

Current Type of Practice: ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Healthplan/Payor-owned

New Type of Practice: ☐ No change ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Healthplan/Payor-owned

Office Hours	Age Range *(if applicable, indicate age range)*

Accepting New Patients

Closing panel to new patients (No longer accepting new patients)
☐ Yes ☐ No

Opening panel to accept new patients (My panel is currently closed and I would like to begin accepting new patients)
☐ Yes ☐ No

Return Form To:

Email: network.administration@bcbsla.com

Phone: 1-800-716-2299, option 3

Mail: BCBSLA – Network Operations
P.O. Box 98029
Baton Rouge, LA 70898-9029