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?	If yes, please specify **New** Specialty	Are you a primary care provider (PCP)?
☐ Yes ☐ No		☐ 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

23XX7231 R10/19

☐ **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 ☐ Health plan/Payor-owned

New Type of Practice: ☐ No change ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Health plan/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

Practice Hours (available appointment hours)

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

For this practice location (please select at least one option):

☐ I am available to see patients at least 16 hours per week on a regular basis.
☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
☐ I read tests or provide other services but do not see patients at this location.
☐ I do not practice here, but this location is within the medical group with which I am employed.

Return Form To: Email: network.administration@bcbsla.com Phone: 1-800-716-2299, option 3
Mail: BCBSLA – PCDM
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