NON-CONTRACTED PROVIDER INFORMATION FORM

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Request to add or update provider information for BCBSAZ claims

- Use this form to add or update provider demographic information for out-of-network claim processing.
- You may also use this form if you are a ***contracted*** provider and are ***not eligible for a secure portal account*** (to access the Provider Information Change Form for contracted providers).

CONTACT PERSON *(Required)*	Name of contact person for questions related to this request		
	Contact information	☐ Phone	☐ Email *(Required)*

Type of provider:
☐ 1. Individual provider (complete sections 1 and 3 below)
☐ 2. Facility (complete sections 2 and 3 below)

SECTION 1 – FOR INDIVIDUAL PROVIDERS ONLY					
INDIVIDUAL PROVIDER INFORMATION *(Required)*	Last Name	First Name		MI	Degree
	Gender ☐ Male ☐ Female	Date of Birth	Social Security Number	Individual NPI Number	Effective Date (mm/dd/yyyy) / /
	Group Name	DBA Name (if applicable)		Organization NPI Number	Effective Date (mm/dd/yyyy) / /
	License Number	Effective Date (mm/dd/yyyy) / /	Primary Specialty (as listed on license)		Secondary Specialty (if applicable)

SECTION 2 – FOR FACILITIES ONLY			
FACILITY INFORMATION *(Required)* Send with this form: A copy of the facility's ADHS (Arizona Department of Health Services) license	Legal Name - as on file with the AZ Corporation Commission	DBA (Doing Business As) Name – if applicable	
	Facility NPI (indicate the NPI used for the primary service location)		Effective Date (mm/dd/yyyy) / /
	AZ License Number (include a copy of the license with this form)		Effective Date (mm/dd/yyyy) / /
	License Type and Specialty (or services provided)		
NOTE	If you are a post-acute care or behavioral health **inpatient** facility provider, we will send you an **Inpatient Facility Questionnaire/Attestation** to complete after we receive this form.		

SECTION 3 – FOR ALL PROVIDERS			
TAX ID and START DATE *(Required)*	Tax ID Number	Start Date (when provider started billing with this tax ID) / /	
PRIMARY ADDRESS Physical location where services are performed *(Required)*	Street Address		Suite
	City	State	Zip
	Phone	Fax	
BILLING ADDRESS (If different than primary address) *(Required)*	Same as primary address: ☐ Yes ☐ No		
	Street Address		Suite
	City	State	Zip
	Phone	Fax	
MAILING ADDRESS (If no mailing address is specified, correspondence will be sent to the billing address)	Same as billing address: ☐ Yes ☐ No		
	Street Address		Suite
	City	State	Zip
	Phone	Fax	
MEDICAL RECORDS (If different than primary address)	Same as primary address: ☐ Yes ☐ No		
	Street Address		Suite
	City	State	Zip
	Phone	Fax	
Additional information/comments (please include a note of attestation if you are a contracted provider and not eligible for a provider portal account)			

Authorized [Electronic] Signature *(Required)*

I am _____, and I verify that I am authorized to submit this request form on behalf of the provider named above. I agree that by entering my name in the electronic signature field below, I am authorizing the request as indicated in this form.

/s/_____ _____
Authorized [Electronic] Signature Date

Sign, save, and email this form to ProvNet@azblue.com *(be sure to attach required documentation)*

or fax to BCBSAZ Provider Partnerships at 602-864-3142

Questions? Call 602-864-4231 or 1-800-232-2345 ext. 4231