



BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

PROVIDER CHANGE NOTIFICATION FORM

Accurate and complete information is important for providers and Blue Cross and Blue Shield of Alabama. Our provider file is utilized for remittance payments, Internal Revenue reporting, directories and publication mailings. To update your information in our provider records, complete this form, sign and mail or fax it to the address below. **Please note that changes to the Payee/Remittance Address and Tax Address require an authorized, original signature of the CEO, CFO, President, Provider or Tax Manager.**

Effective Date of Change		
Month	Date	Year
<input type="text"/>	- <input type="text"/>	- <input type="text"/>

Current information			
Provider Name		Individual NPI <i>(National Provider Identifier)</i>	<input type="text"/>
Practice Name		Tax ID Number	<input type="text"/>
Current Address			
City		State	Zip
Appointment Phone	Office Phone	Fax Number	
Office E-mail		Provider E-mail	

Please indicate any updates below.			
New Office Address			
City		State	Zip
Appointment Phone	Office Phone	Fax Number	
Office E-mail		Provider E-mail	
* New Payee/Remit Address <input type="checkbox"/> <i>(Same as above)</i>			
City		State	Zip
Payee/Remit Phone	Fax Number	Payee NPI	<input type="text"/>
* New Tax Address <input type="checkbox"/> <i>(Same as above)</i>			
City		State	Zip
New Correspondence Address <input type="checkbox"/> <i>(Same as above)</i>			
City		State	Zip

* Requires authorized, original signature of the CEO, CFO, President, Provider or Tax Manager.			
I certify this information is complete and correct to the best of my knowledge.			
_____		_____	_____
Signature <i>(Required)</i>		Title <i>(Required)</i>	Date

Submission Instructions	
Fax Fax the signed and completed form to: Attn: Credentialing 1-205-220-9545	Mail Blue Cross and Blue Shield of Alabama, Attn: Credentialing Post Office Box 362142, Birmingham, AL 35236-2142