PROVIDER CHANGE FORM

Blue Cross complete of Michigan

REQUIREMENTS & GUIDELINES

REQUIREMENTS:

To efficiently process the change request, please complete the required fields in the *CURRENT PRACTICE INFORMATION* section.
The following types of changes require the submission of the W-9 form (*tax form which certified an individual's tax identification number*)

1. Billing address change
2. Tax ID change
3. Group name change
4. Change of ownership

GUIDELINES:

1. If you are submitting a request to change a physician's name, please submit a copy of a marriage license, divorce decree, etc. as supporting documentation.
2. If your office has a Tax Identification Number change, please submit to Blue Cross Complete as soon as it is available to ensure timely and accurate processing. A delay in notification may interrupt claims processing.
3. Physicians **must** complete Blue Cross Complete credentialing before they will be added to your practice as a participating provider. You may access the enrollment forms at MiBlueCrossComplete.com/providers

CURRENT PRACTICE INFORMATION ALL FIELDS IN THIS SECTION ARE REQUIRED

Type of Provider: ☐ Ancillary ☐ Specialist ☐ Primary care practitioner ☐ Hospital ☐ Urgent care

Type 1 NPI: _____ Type 2 NPI: _____ Tax Identification Number: _____

Provider name: _____ Group name: _____

Contact person: _____ Phone: _____ Email: _____

Authorizing signature: _____ Authorizing signature printed: _____

Effective date of change: _____ Today's date: _____

PROVIDER CHANGE INFORMATION

PROVIDE COMPLETE INFORMATION – This request will be processed for Blue Cross Complete of Michigan. Changes will be effective within 45 days. If any of these changes result in a change on your W-9, you must submit a copy of your W-9 with this change form. Please use the check box to identify your change request. If you have a change not listed below, please provide the request on your letterhead detailing your change. Please print or type.

☐ **Remove a practice address** ☐ **Correct a practice address** ☐ **Telephone/fax change** ☐ **Office hours** ☐ **Include in provider directory**
☐ **Exclude from provider directory** ☐ **Update specialty** ☐ **Billing address change***

Street: _____ City: _____ State: _____ Zip: _____

Phone: (_____)_____ Fax: (_____)_____ Office hours: _____ Type 2 NPI: _____

Is this location an FQHC, RHC, THD or LHD? ☐ Yes ☐ No

☐ **Tax Identification change*** New Tax Identification Number: _____ Type 2 NPI: _____

☐ **Change of ownership*** _____ Effective date of ownership: _____
Legal business name of new owner

Liability Assumed ☐ Yes ☐ No

☐ **Name change only** Current name: _____ New name: _____

☐ **Panel changes**
☐ Open panel to members
☐ Close panel to all new members, but keep existing members
☐ Close panel to all members
☐ Close panel to all members (new and existing) and reassign to the following practitioner: _____
Last name, First name

☐ **Termination from Blue Cross Complete** Explanation/Reason for termination: _____

If a PCP, who will be assuming your patient panel: _____ Assuming PCP NPI: _____
Last name, First name

PLEASE EMAIL, FAX OR MAIL THIS CHANGE FORM, ALONG WITH SUPPORTING DOCUMENTATION, TO:
Blue Cross Complete of Michigan, Attn: Provider Data Management, 4000 Town Center Suite 1300, Southfield MI 48075; Fax: 1-855-306-9762
BCCProviderData@mibluecrosscomplete.com

***INDICATES A W-9 FORM IS REQUIRED**