

700 Market Square, PO Box 1948, Parkersburg, WV 26102

**Instructions:** The information requested below is required by Mountain State Blue Cross Blue Shield for the proper issuance of payments/Provider Explanation of Benefits (EOB) and other related information to your practice/group/billing address. (Note: This information must be consistent with the information provided in blocks 25, 31 and 33 when billing for your services on the HCFA 1500 claim form.) Please return this form with your signed Agreement(s) to Mountain State Blue Cross Blue Shield, attention Provider Relations Department.

Please use this form to identify changes in your locations, Tax ID or practice arrangement. Return this form with your signed Agreement(s) to Mountain State Blue Cross Blue Shield, attention Provider Relations Department.

**Please complete one Provider Reimbursement/Change Form per Tax ID. (Please refer to back of form if additional space is needed.)**

**New Provider or Add to Staff Information**

Tax Identification Number		Provider Pay To Number		Service Provider Number		Organizational NPI (Type 2)	
Practice Name				Effective Date		<input type="checkbox"/> Individual /Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other (Check Appropriate Box)	
Street Address Of Primary Office				Telephone			
City		State	County		Zip	Office Fax Number	
Reimbursement Name ( <b>Attach Copy of W-9</b> )				Reimbursement Address			
City		State	County		Zip	Telephone	

**Changes**

<input type="checkbox"/> Practice Name Change – (Group) From: _____ To: _____	
Effective Date: _____ Indicate which location this change applies to: _____	

<input type="checkbox"/> Provider Name Change – Individual Effective Date: _____		From: _____ To: _____	
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<input type="checkbox"/> Address Change -- From: Effective Date: _____ Practice Name: _____ Old Address: _____ City, State, Zip: _____		To: Practice Name: _____ New Address: _____ City, State, Zip: _____	
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<input type="checkbox"/> Tax ID Change: Effective Date: _____		Old Number: _____ New Number: _____	
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**Cancellations**

Provider Number Cancellation: <u>Tax ID &amp; Suffix:</u> _____ Practice Location: _____ Name: _____ Address: _____ City, State, Zip: _____		<b>Reason: (please include dates in field provided)</b> Effective Date: _____ <input type="checkbox"/> No longer here _____ <input type="checkbox"/> Retired _____ <input type="checkbox"/> Deceased _____ <input type="checkbox"/> Other _____	
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**If additional space is needed please copy and attach to Provider Reimbursement/Change Form**

**Additional provider information under same Tax ID**

1. Individual Provider Name		Individual NPI (Type 1)	Primary Specialty	Effective Date
Street Address		Telephone	Practice locations listed below (Check appropriate box) A. <input type="checkbox"/> B. <input type="checkbox"/> C. <input type="checkbox"/> D. <input type="checkbox"/>	
City	State	County	Zip	Office Fax Number

2. Individual Provider Name		Individual NPI (Type 1)	Primary Specialty	Effective Date
Street Address		Telephone	Practice locations listed below (Check appropriate box) A. <input type="checkbox"/> B. <input type="checkbox"/> C. <input type="checkbox"/> D. <input type="checkbox"/>	
City	State	County	Zip	Office Fax Number

3. Individual Provider Name		Individual NPI (Type 1)	Primary Specialty	Effective Date
Street Address		Telephone	Practice locations listed below (Check appropriate box) A. <input type="checkbox"/> B. <input type="checkbox"/> C. <input type="checkbox"/> D. <input type="checkbox"/>	
City	State	County	Zip	Office Fax Number

4. Individual Provider Name		Individual NPI (Type 1)	Primary Specialty	Effective Date
Street Address		Telephone	Practice locations listed below (Check appropriate box) A. <input type="checkbox"/> B. <input type="checkbox"/> C. <input type="checkbox"/> D. <input type="checkbox"/>	
City	State	County	Zip	Office Fax Number

**Additional location information under same Tax ID and Reimbursement Name**

A. Practice Name			Effective Date	
Street Address			Telephone	
City	State	County	Zip	Office Fax Number

B. Practice Name			Effective Date	
Street Address			Telephone	
City	State	County	Zip	Office Fax Number

C. Practice Name			Effective Date	
Street Address			Telephone	
City	State	County	Zip	Office Fax Number

D. Practice Name			Effective Date	
Street Address			Telephone	
City	State	County	Zip	Office Fax Number