Blue Cross complete of Michigan

PROVIDER CHANGE FORM

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: _____________________________Today's Date: _______________

Contact person: ________________________ Phone: __________________________ Email:___________________________________

Authorizing signature: _________________________________ Authorizing signature printed: _______________________________

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. Please print or type.

☐ **Adding a practice** ☐ **Deleting a practice address** ☐ **Billing address change*** ☐ **Telephone/fax change** ☐ **Office hours**
☐ **Include in provider directory** ☐ **Exclude in provider directory** ☐ **Correct a practice address**

Street: ____City:_________________State: __________Zip:___________

Phone: (______)_______________ Fax: (_____)_______________________Office hours: ____

☐ **Tax Identification change*** New Tax Identification Number: _____________________________________

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

A change in ownership will also require the completion of the MDHHS Ownership Attestation which can be located at MiBlueCrossComplete.com/providers

☐ **Name change only** Current name: _________________________________ New name: __________________________________

☐ **Panel changes**
☐ 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: ____
Last name, First name

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

PLEASE EMAIL, FAX OR MAIL THIS CHANGE FORM, ALONG WITH SUPPORTING DOCUMENTATION, TO:
Blue Cross Complete of Michigan, Attn: Provider Data Management, 100 Galleria Officentre; Suite 210, Southfield MI 48034 Fax #: 1-855-306-9762
BCCProviderData@mibluecrosscomplete.com

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