



PROVIDER ADMINISTRATION COMMUNICATION FORM

Use this form to communicate changes in your practice information to Blue Cross & Blue Shield of Mississippi (BCBSMS).

Submit changes for: BCBSMS Only AHS Only Both **Date Submitted:** _____

PROVIDER INFORMATION (All fields must be completed.)

Provider Name:		Provider ID #:
Contact Name/Title:		Provider NPI #:
Telephone #:	Fax #:	E-mail Address:

**CHANGE IN PRACTICE ADDRESS (For Change to Existing Practice Location Only)
(A new practice location requires an Additional Location Application.)**

Effective Date of Change: _____

<u>Old Address</u>			<u>New Address</u>		
Office Name:			Office Name:		
Street Address:			Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Appointment Telephone #:			Appointment Telephone #:		
Billing Address:			Billing Address:		
City:	State:	Zip:	City:	State:	Zip:
Billing Telephone #:			Billing Telephone #:		
Group NPI #:			Group NPI #:		

CHANGE IN PROVIDER TAX ID# (Attach W-9 form or 147-C letter from IRS.)

Effective Date of Change: _____

Old Tax ID#:	New Tax ID#:
Clinic/Group Name:	Clinic/Group Name:

CHANGE IN SPECIALTY (Attach a copy of Board Certification.)

Previous Specialty:	New Specialty:
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CHANGE IN HOSPITAL AFFILIATION (Attach an explanation.)

Previous Affiliation:	New Affiliation:
Staff Privileges:	Staff Privileges:

REQUEST FOR PROVIDER TERMINATION (Check reason for request.)

Effective Date of Termination: _____

<input type="checkbox"/> Provider left clinic.	<input type="checkbox"/> Provider moved out of state.	<input type="checkbox"/> Other reason (please list):
<input type="checkbox"/> Provider retired.	<input type="checkbox"/> Provider is deceased.	
Forwarding Address and New Telephone # (if known):		

**SEND COMPLETED FORM IN ONE OF THE FOLLOWING WAYS
(All information changes must be submitted in writing.)**

<p>Mail To: Blue Cross & Blue Shield of Mississippi Attn: Provider Administration P O Box 1043 Jackson, MS 39215-1043</p>	<p>Fax To: 601-664-5107</p> <p>Email To: providerdatabase@bcbsms.com</p>
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