



### Provider File Update Form

Please use this form to provide to us any changes in address, telephone numbers, etc.

Name of Provider/Group: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
NPI Number: \_\_\_\_\_ Tax ID Number: \_\_\_\_\_

Please Check All That Apply:

- Name Change
- Payee Address Change
- Telephone Number Change
- Office Address Change
- Tax ID Number Change
- Other Change (Explain Below)
- Hospital Affiliation

Effective Date of Change: \_\_\_\_\_

New Name(s): \_\_\_\_\_  
Tax ID Number: \_\_\_\_\_

New Payee Address:  
Street Address/Suite No./P.O. Box No.: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax \_\_\_\_\_

New Office Address:  
Street Address/Suite No./P.O. Box No.: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax \_\_\_\_\_

**Delete the following Address:**

(1) Street Address/Suite No./P.O. Box No.: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax \_\_\_\_\_

(2) Street Address/Suite No./P.O. Box No.: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax \_\_\_\_\_

New Tax ID Number: \_\_\_\_\_

Hospital Affiliation(s):  
Hospital Name: \_\_\_\_\_ City: \_\_\_\_\_  
Hospital Name: \_\_\_\_\_ City: \_\_\_\_\_  
Hospital Name: \_\_\_\_\_ City: \_\_\_\_\_  
Hospital Name: \_\_\_\_\_ City: \_\_\_\_\_

**ADDITIONAL INFORMATION:**

If you are no longer practicing under a Tax ID number, or if you have joined a group practice and file claims under the group's Tax ID number, please provide updated and former Tax ID information below:

\_\_\_\_\_  
Name of Individual Submitting Change Form: \_\_\_\_\_ Title: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

Mail the completed form to BCBSIL, 300 E. Randolph St., Chicago, IL 60601-5000, Attention: Provider Services – 23rd floor, or Fax this form to Provider Services, 1-312-856-1946.