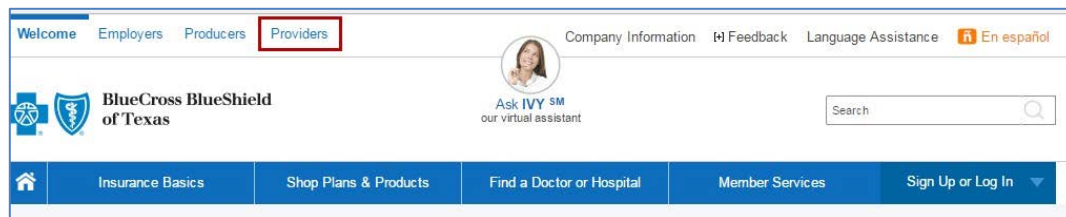


# Demographic Change Form User Guide

## Access the Demographic Change Form

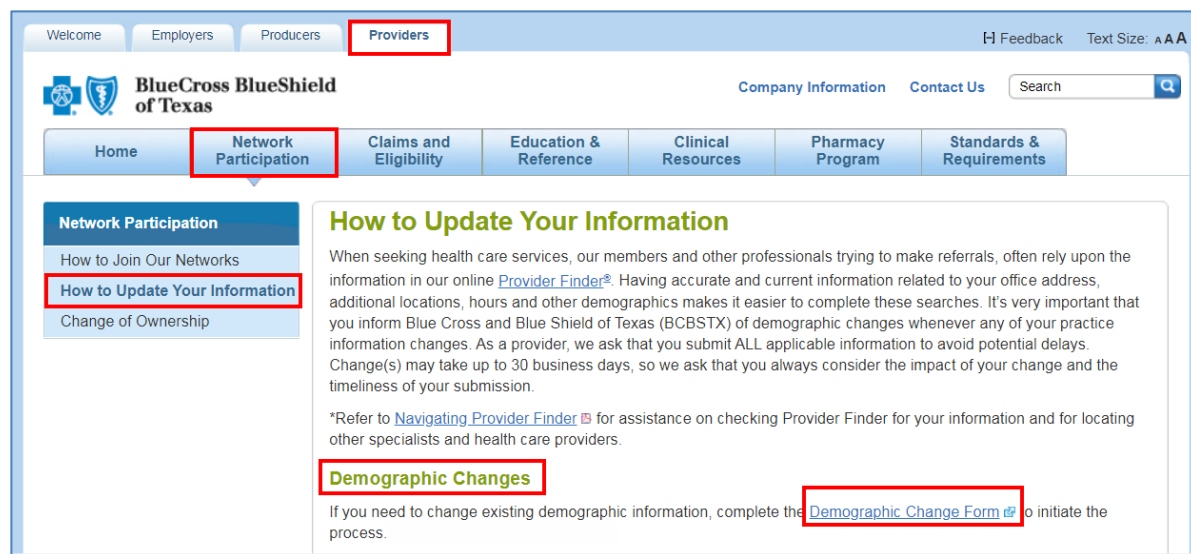
1. For best results use the **Google Chrome** browser.
2. To access the form from the [Blue Cross Blue Shield of Texas website](#), click the **Providers** tab.



3. On the **Providers** Tab, select the **Network Participation** tab and then select **How to Update Your Information** from the list of options.



4. Scroll to Demographic Changes, then select Demographic Change Form.



# Demographic Change Form User Guide

5. Enter your information. Notice that \* indicates a required field.

## Change Existing Demographic Information

---

### Identification Information

*\* Indicates required field*

\* Type of Provider    Individual Provider    Locum Tenens    Group/Clinic    Facility/Ancillary

### Submitter Information

\* First Name: \_\_\_\_\_

\* Last Name: \_\_\_\_\_

\* Telephone Number:Ext: \_\_\_\_\_  
Numeric digits only.   Numeric digits only.

\* Job Title/Position: \_\_\_\_\_

\* Email Address: \_\_\_\_\_  
you@example.com

### Provider Information

\* Name of Provider/Group: \_\_\_\_\_

\* Tax ID Number: \_\_\_\_\_

Rendering NPI: \_\_\_\_\_

\* Billing NPI Number: \_\_\_\_\_

\* Type    Type 1 (Individual)    Type 2 (Group)

## Demographic Change Form User Guide

---

6. \* **Type of Provider** (**Note:** Form needs to be completed and submitted for **each** applicable provider and/or group provider record ID#)

- A. Individual Provider is a provider who will not be employing another professional provider
  - a. A provider who will be using his/her social security number (SSN) for tax purposes
  - b. A provider whose Federal Tax Identification Number (TIN) is legally in the provider's name
  - c. A provider who is not incorporated
  - d. A provider who practice exclusively in an inpatient or freestanding facility. Eligible specialties include, but are not limited to, Anesthesia, Emergency Medicine, Radiology, Pathology, Neonatology & Hospitalist.
- B. Locum Tenens is a provider who temporarily fulfills the duties of another provider. These professionals are still governed by their respective regulatory bodies
- C. Group/Clinic
  - a. A provider who has a practice with more than one professional provider
  - b. A provider whose Federal Tax Identification Number (TIN) has a corporate legal name
  - c. A provider whose billing entity is incorporated
- D. Facility/Ancillary are inpatient or freestanding facilities or ancillary (i.e., DME, Hearing Aid, Rehab) providers.

7. **Submitter Information**

Required contact information of person completing the Demographic Change Form, should we have questions on the data submitted.

- First and Last Name
- Daytime Telephone Number
- Job Title/Position
- Email Address

8. **Provider Information**

- Name of Provider/Group
- Tax ID
- Rendering NPI -A National Provider Identifier (NPI) is a 10-digit numerical identifier for providers of health care services. Type 1 is at the practitioner level. It is a personal identifying number for the individual healthcare provider. An individual is eligible for only one NPI.
- Billing NPI Number - A National Provider Identifier (NPI) is a 10-digit numerical identifier for organizations such as physician groups, facilities, hospitals, home health agencies, labs and durable medical equipment (DME) providers.
  - Organizations must determine if they have "subparts" that need to be uniquely identified in HIPAA standard transactions with their own NPIs. A subpart is a component of an organization health care provider that furnishes health care and is not itself a separate legal entity.
  - If an individual is a health care provider and is incorporated, they may need to obtain an NPI for themselves (Type 1) and an NPI for their corporation or **limited liability company (LLC)** (Type 2).  
See the Centers for Medicare & Medicaid Services (CMS) National Plan and Provider Enumeration System to [search the NPI Registry](#) or to apply for your NPI number.

# Demographic Change Form User Guide

Below screenshot is for Individual, Locum Tenens, or Facility/Ancillary Providers:

## Change Existing Demographic Information

---

**Type of Change**

- Name
- NPI/Tax
- Office Physical Address
- Billing Address
- Credentialing Address
- Administrative Address
- Other Provider Updates

[Back](#)[Next](#)

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Below screenshot is for Group/Clinic use. It has the “Remove Provider from Group/Location” option at the bottom:

## Change Existing Demographic Information

---

**Type of Change**

- Name
- NPI/Tax
- Office Physical Address
- Billing Address
- Credentialing Address
- Administrative Address
- Other Provider Updates

---

- Remove Provider from Group/Location

[Back](#)[Next](#)

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# Demographic Change Form User Guide

Next Screenshots are in chronological order based on the Type of Change selected in the previous screenshot

## Name:

### Change Existing Demographic Information

---

#### Name Change

*\* Indicates required field*

Attach signed and dated W-9 for name change. If you have multiple titles please list additional titles in the below comments box.

<b>Current Name</b>	<b>New Name</b>
First Name: _____	First Name: _____
Middle Name _____	Middle Name: _____
Last Name: _____	Last Name: _____
Suffix: _____ ▼	Suffix: _____ ▼
Current Title: _____	New Title: _____
Current Practice Name: _____	New Practice Name: _____

#### Additional Information

Comments:

**\* Effective Date of Change:**

\_\_\_\_\_

**Attach Documentation:**

Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.

Combined file size = 0.0 MB

No file chosen

Add another file

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# Demographic Change Form User Guide

## NPI/Tax ID:

### Change Existing Demographic Information

#### NPI/Tax ID Change

\* Indicates required field

Attach signed and dated W-9 with correct classification box checked.

#### Current Information

Current Billing NPI Number:

Current Tax ID Number:

#### New Information

New Billing NPI Number:

New Tax ID Number:

#### Additional Information

Comments:

\* Effective Date of Change:



Attach Documentation:

Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.

Combined file size = 0.0 MB

No file chosen

Add another file

Back

Submit Form

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# Demographic Change Form User Guide

**Office Physical Address/Satellite location:** Complete all information.

For the Primary Location reply:

“Yes”, will replace current main physical location information.

“No” adds information as a directory location/satellite address.

### Office Physical Address/Telephone/Fax/Email/Hours of Operation Change

\* Indicates required field

Complete a separate form for each office physical address change request. This information is utilized for the member directories. A P.O. Box address will not be accepted as an official physical address. If your primary address change involves moving to a different county, this could impact your claims payment.

<b>Current Office Physical Address</b>	<b>New Office Physical Address</b>
Address Line 1: _____	Address Line 1: _____
Address Line 2: _____	Address Line 2: _____
City: _____	City: _____
State: Zip Code: _____	State: Zip Code: _____
Telephone Number Ext: <small>Numeric digits only Numeric digits only</small> _____	Telephone Number Ext: <small>Numeric digits only Numeric digits only</small> _____
Email: <small>you@example.com</small> _____	Email: <small>you@example.com</small> _____
Fax Number: <small>Numeric digits only. For example: 1234567890</small> _____	Fax Number: <small>Numeric digits only. For example: 1234567890</small> _____
	Primary Location: <input type="radio"/> Yes <input type="radio"/> No
	Supervising Physician: _____
	Accepting New Patients: _____

### Hours of Operation Change

For more than one set of hours for same day, please note in the comments box below.

Open 24/7

Mon \_\_\_\_\_ to \_\_\_\_\_ Wed \_\_\_\_\_ to \_\_\_\_\_ Fri \_\_\_\_\_ to \_\_\_\_\_ Sun \_\_\_\_\_ to \_\_\_\_\_  
Tue \_\_\_\_\_ to \_\_\_\_\_ Thu \_\_\_\_\_ to \_\_\_\_\_ Sat \_\_\_\_\_ to \_\_\_\_\_

### Americans with Disabilities Act (ADA)

\* Are the following standards in accordance with the Americans with Disabilities Act?  Yes  No

If yes, please check at least one of the following

<input type="checkbox"/> Site Accessible	<input type="checkbox"/> Exam Room	<input type="checkbox"/> Restroom
<input type="checkbox"/> Parking Accessibility	<input type="checkbox"/> Exam Table	<input type="checkbox"/> Scale
<input type="checkbox"/> Exterior Building	<input type="checkbox"/> Office Reception Area	
<input type="checkbox"/> Interior Building	<input type="checkbox"/> Close Proximity to Public Transportation	

### Treating Categories

\* Does the provider treat the following?  
Please check at least one

<input type="checkbox"/> Homebound	<input type="checkbox"/> Chronic Illness	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Homeless	<input type="checkbox"/> Serious Mental Illness	<input type="checkbox"/> Physical Disabilities
<input type="checkbox"/> Blindness or Visually Impaired	<input type="checkbox"/> Co-occurring Disorders	<input type="checkbox"/> Deafness or Hard of Hearing

### Additional Information

Comments:  
\_\_\_\_\_

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

Attach Documentation:  
Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per requested type.

Combined file size = 0.0 MB  
 No file chosen

# Demographic Change Form User Guide

## Billing Address:

### Change Existing Demographic Information

#### Billing Address/Telephone/Fax/Email Change

\* Indicates required field

Changes requested to a group's information will only be accepted if submitted by the group. *Supporting documentation must be submitted on the group letterhead.*

#### Current Billing Address

Address Line 1:

---

Address Line 2:

---

City:

---

State:      Zip Code:

Telephone Number:      Ext:

Email:

Fax Number:

#### New Billing Address

Address Line 1:

---

Address Line 2:

---

City:

---

State:      Zip Code:

Telephone Number:      Ext:

Email:

Fax Number:

#### Additional Information

Comments:

\* Effective Date of Change:



Attach Documentation:

Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .bt, .xls, .xlsx. User can select only up to 5 total files per request type.

Combined file size = 0.0 MB

No file chosen

Add another file

Back

Submit Form



# Demographic Change Form User Guide

## Credentialing Address:

### Change Existing Demographic Information

#### Credentialing Address/Telephone/Fax/Email Change

\* Indicates required field

Changes requested to a group's information will only be accepted if submitted by the group. Supporting documentation must be submitted on the group letterhead.

#### Current Credentialing Address

Address Line 1:

Address Line 2:

City:

State: Zip Code:

Telephone Number: Ext:

Email:

Fax Number:

Credentialing Contact Name:

#### New Credentialing Address

Address Line 1:

Address Line 2:

City:

State: Zip Code:

Telephone Number: Ext:

Email:

Fax Number:

#### Additional Information

Comments:

\* Effective Date of Change:

Attach Documentation:

Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.

Combined file size = 0.0 MB

No file chosen

Add another file

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# Demographic Change Form User Guide

## Administrative Address:

### Change Existing Demographic Information

#### Administrative Address/Telephone/Fax/Email Change

\* Indicates required field

Changes requested to a group's information will only be accepted if submitted by the group. Supporting documentation must be submitted on the group letterhead.

#### Current Administrative Address

Address Line 1:

---

Address Line 2:

---

City:

---

State:      Zip Code:

▼      \_\_\_\_\_

Telephone Number:      Ext:

*Numeric digits only.*      *Numeric digits only.*

Email:

*you@example.com*

Fax Number:

*Numeric digits only. For example: 1234567890*

Administrative Contact Name:

---

#### New Administrative Address

Address Line 1:

---

Address Line 2:

---

City:

---

State:      Zip Code:

▼      \_\_\_\_\_

Telephone Number:      Ext:

*Numeric digits only.*      *Numeric digits only.*

Email:

*you@example.com*

Fax Number:

*Numeric digits only. For example: 1234567890*

---

#### Additional Information

Comments:

\* Effective Date of Change:

\_\_\_\_\_ 

Attach Documentation:

Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .bt, .xls, .xlsx. User can select only up to 5 total files per request type.

Combined file size = 0.0 MB

No file chosen

Add another file

Back

Submit Form

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# Demographic Change Form User Guide

## Other Provider Updates:

### Change Existing Demographic Information

#### Other Provider Updates

\* Indicates required field

##### Current Information

Hospital Privilege (list all):

\_\_\_\_\_

Ambulatory Surgery Center Privileges (list all):

\_\_\_\_\_

License Number:


\_\_\_\_\_

Specialty:

\_\_\_\_\_

Subspecialty:

\_\_\_\_\_

Specialty Effective Date: \_\_\_\_\_ 

Specialty Certification Date: \_\_\_\_\_ 

Board Certified:  Yes  No

Provide Lactation Services:  Yes  No

##### New Information

Hospital Privilege (list all):

\_\_\_\_\_

Ambulatory Surgery Center Privileges (list all):

\_\_\_\_\_

License Number:

\_\_\_\_\_

Specialty:

\_\_\_\_\_

Subspecialty:

\_\_\_\_\_

Specialty Effective Date: \_\_\_\_\_ 

Specialty Certification Date: \_\_\_\_\_ 

Board Certified:  Yes  No

Provide Lactation Services:  Yes  No

Date Of Birth: \_\_\_\_\_ 

DEA Number:

\_\_\_\_\_


DEA Number Expiration Date: \_\_\_\_\_ 

Languages (spoken or written):

\_\_\_\_\_

Medical School Name:

\_\_\_\_\_

Date of Graduation: \_\_\_\_\_ 

Residency Hospital Name:

\_\_\_\_\_

Residency Period:

From \_\_\_\_\_  To \_\_\_\_\_ 

Ethnicity:

\_\_\_\_\_ ▼

#### Additional Information

Comments:

\_\_\_\_\_

\* Effective Date of Change:

\_\_\_\_\_ 

Attach Documentation:

Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.

Combined file size = 0.0 MB

No file chosen

Add another file

Back

Submit Form

# Demographic Change Form User Guide

## Remove Provider from Group/Location:

### Remove Provider from Group/Location

\* Indicates required field

If you are removing a provider from more than two service locations, please Attach an Excel file with all applicable locations.

#### Individual Provider Information

\* Individual Provider Name:

Individual's Type 1 NPI:

Other ID Number (Eg: Medicaid #, API #, LTSS #, TPI #):

#### Provider Location Information

Remove Provider from all locations on file

Address Line 1:

Address Line 2:

City:

State:      Zip Code:

\* Reason for leaving:

\* Effective Date of Termination:



Add another location for removal

#### Additional Information

Comments:

Attach Documentation:

Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.

Combined file size = 0.0 MB

No file chosen

Add another file

\*  I certify that the information submitted within this form is accurate and complete.

Back

Submit Form