BlueCross BlueShield of Oklahoma

PROVIDER NOTIFICATION FORM

☐ **Add –** New/Existing providers request to add a new/additional location to their provider data file.

☐ **Update –** New/Existing providers request to update information on a current location in their provider data file.

☐ **Close –** Existing providers request to close a location where services are no longer provided.

If you are interested in becoming a contracted provider, please complete the appropriate **ONBOARDING FORM**

PLEASE COMPLETE A SEPARATE FORM FOR EACH ACTION REQUESTED AND/OR FOR ADDITIONAL LOCATIONS

SUBMIT FORM WITH W9 AND COPY OF YOUR OKLAHOMA HEALTHCARE LICENSE

Completing the form for:

☐ **Group/Clinic** (if change does not apply to all affiliated providers under this Tax ID, please complete a separate form for all individual providers affected by this change.)

☐ **Individual Provider**
☐ **Locum Tenens**

Provider Name:	Title:	DOB:
Effective Date:	Rendering/Individual NPI#:	
State License Number:	SSN:	
Where do you render services for this location? (i.e. office, surgery center and/or hospital):		

I WANT TO ADD OR CHANGE:	I WANT TO CLOSE:
☐ Group Name (if applicable) Current Group Name: New Group Name:	☐ Group Name (if applicable) Current Group Name: New Group Name:
☐ Group/Organizational NPI (if applicable) Current Group NPI: New Group NPI:	☐ Group/Organizational NPI (if applicable) Current Group NPI: New Group NPI:
☐ Tax ID# (attach copy of W9) Current Tax ID#: New Tax ID#:	☐ Tax ID# (attach copy of W9) Current Tax ID#: New Tax ID#:
☐ Physical address Current physical address: New Physical Address:	☐ Physical address Current physical address: New Physical Address:
☐ Pay to Address (where the check goes) Current Pay to address: New Pay to Address:	☐ Pay to Address (where the check goes) Current Pay to address: New Pay to Address:
☐ Appointment Phone Number Current phone: New phone:	☐ Appointment Phone Number Current phone: New phone:
☐ Fax Number Current fax: New fax:	☐ Fax Number Current fax: New fax:
☐ Supervising Physician Current Sup Phys: New Sup Phys:	
☐ Specialty Current Specialty: New Specialty: Nephrology Only – Dialysis Center Affiliations:	
☐ Hospital and/or Ambulatory Surgery Center Privileges Current: New:	

COMPLETION OF THIS FORM DOES NOT MEAN THAT YOU ARE A CONTRACTED PROVIDER

Contact Information

☐ Credential Contact

Name:

Email:

Phone:

Fax:

Mailing Address:

☐ Communication Contact

Name:

Email:

Phone:

Fax:

Mailing Address:

☐ Contracting Contact

Name:

Email:

Phone:

Fax:

Mailing Address:

Laboratory Services

Do you render laboratory services? ☐ Y or ☐ N

Are you a reference laboratory? ☐ Y or ☐ N

If Yes, please provide your CLIA number and describe the testing methodology performed.

CLIA Number:

Testing Methodology:

Directory Status Changes

Patient Panel Status:

☐ **Accepting –** Does this change affect: ☐ HMO ☐ PPO ☐ Medicare Advantage

☐ **Established Patients Only –** Does this change affect: ☐ HMO ☐ PPO ☐ Medicare Advantage

☐ **Not Accepting –** Does this change affect: ☐ HMO ☐ PPO ☐ Medicare Advantage

Age Limits:

Other Practice Limitations:

☐ Current Office Hours:

Mon	to	Tue	to
Wed	to	Thur	to
Fri	to	Sat	to
Sun	to		

☐ New Office Hours:

Mon	to	Tue	to
Wed	to	Thur	to
Fri	to	Sat	to
Sun	to		

Please add **bcbsok.com** and **HCSC.net** to your email settings to receive email from us in your inbox, or email may be sent to your SPAM or JUNK folder.
Return the signed and completed form via email to **oknetworkmanagement@bcbsok.com** or via fax at 918-549-2141.

☐ I have attached the required documentation as noted above and I certify that the above disclosed information is true and correct to the best of my knowledge as of the date set forth below. I hereby release this information to Blue Cross and Blue Shield of Oklahoma for the purpose of establishing and/or updating my BCBSOK Provider Record.

Provider Signature:

Date:

COMPLETION OF THIS FORM DOES NOT MEAN THAT YOU ARE A CONTRACTED PROVIDER