

For Internal Use Only (Individual Application)			
Internal #:	Provider #1:	Provider #2:	Reason:
Employee Name:		Items Sent:	

## Provider Information Change Form

### I. PERSONAL INFORMATION

Name: \_\_\_\_\_ Gender: **M** or **F** Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Middle Last Suffix Degree (MD,RN, etc.) (Circle One) MM / DD / YY

BCBST Provider Number: \_\_\_\_\_ NPI Number: \_\_\_\_\_ Medicare Provider Number: \_\_\_\_\_  
 Tax ID: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
(Required) (W-9 Required for Tax Change) (Required)

State Lic. # \_\_\_\_\_ DEA # \_\_\_\_\_ UPIN # \_\_\_\_\_ Type of Provider: PCP \_\_\_\_\_ Specialist \_\_\_\_\_ Other \_\_\_\_\_  
 Specialty: \_\_\_\_\_ Primary Language Spoken: \_\_\_\_\_ Secondary Language Spoken: \_\_\_\_\_

Race / Ethnicity (Optional*)		
<input type="checkbox"/> Asian	<input type="checkbox"/> Black (not Hispanic) or African-American	<input type="checkbox"/> Pacific Islander
<input type="checkbox"/> Asian American	<input type="checkbox"/> Hispanic	<input type="checkbox"/> White (not Hispanic)
<input type="checkbox"/> Alaska Native	<input type="checkbox"/> North American Indian	<input type="checkbox"/> Other (please specify) _____
*While this section is optional, we ask that you complete for accreditation purposes and to maintain a comprehensive provider directory.		

### II. LOCATION INFORMATION

Do you currently work for an Outpatient Diagnostic Facility?  Yes  No

Primary Location Information			
Practice/Group Name:			Pay To: <input type="checkbox"/> Self <input type="checkbox"/> Group
Address:	City:	State:	Zip: *E-mail address:
Phone: ( ) - Ext:	Fax: ( ) -	After Hours: ( ) - Ext:	Web site address:
Contact Information:	Name:	Title:	Phone: ( ) - Ext:

\*This email address will be used to communicate important information. It is your responsibility to notify BCBST of any changes to the address.

Is this a new location? \_\_\_\_\_ If so, what is the effective date of your new location? \_\_\_\_\_

Office Hours						
(If this section is left blank, office hours will default to M-F 8am to 5pm)						
Time Zone	<input type="checkbox"/> Central Time	<input type="checkbox"/> Eastern Time	From	To	From	To
Monday	<input type="checkbox"/> Closed					
Tuesday	<input type="checkbox"/> Closed	<input type="checkbox"/> Same as Monday				
Wednesday	<input type="checkbox"/> Closed	<input type="checkbox"/> Same as Monday				
Thursday	<input type="checkbox"/> Closed	<input type="checkbox"/> Same as Monday				
Friday	<input type="checkbox"/> Closed	<input type="checkbox"/> Same as Monday				
Saturday	<input type="checkbox"/> Closed	<input type="checkbox"/> Same as Monday				
Sunday	<input type="checkbox"/> Closed	<input type="checkbox"/> Same as Monday				
Handicap accessible?	Hospital Based Prov?	Patient Accepting Status		24-hour coverage?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> New and Existing <input type="checkbox"/> Existing Only* (*Note: You must be closed to all payers)		<input type="checkbox"/> Yes <input type="checkbox"/> No		

### III. ADDITIONAL LOCATION INFORMATION

If you need additional locations, make copies of this page.

Additional Location Information			
<input type="checkbox"/> Add Location <input type="checkbox"/> Change Contact Information <input type="checkbox"/> Remove Location			
Address:		City:	State:      Zip:      *E-mail address:
Phone: (   ) -      Ext:	Fax: (   ) -	After Hours: (   ) -      Ext:	Web site address:
<b>Handicap accessible?</b>	<b>Patient Accepting Status</b>		<b>24-hour coverage?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> New and Existing <input type="checkbox"/> Existing Only* (*Note: You must be closed to all payers)		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Contact Information:</b>	Name:	Title:	Phone: (   ) -      Ext:

Additional Location Information			
<input type="checkbox"/> Add Location <input type="checkbox"/> Change Contact Information <input type="checkbox"/> Remove Location			
Address:		City:	State:      Zip:      *E-mail address:
Phone: (   ) -      Ext:	Fax: (   ) -	After Hours: (   ) -      Ext:	Web site address:
<b>Handicap accessible?</b>	<b>Patient Accepting Status</b>		<b>24-hour coverage?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> New and Existing <input type="checkbox"/> Existing Only* (*Note: You must be closed to all payers)		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Contact Information:</b>	Name:	Title:	Phone: (   ) -      Ext:

### IV. ADDRESS INFORMATION

Mailing Address			
<input type="checkbox"/> Add Location <input type="checkbox"/> Change Location <input type="checkbox"/> Remove Location			
<input type="checkbox"/> Same as primary <input type="checkbox"/> Other (Please specify)	Address:		City:      State:      Zip:
	Phone: (   ) -      Ext:	Fax: (   ) -	After Hours: (   ) -      Ext:
Effective Date of Address change: _____			
Corporate Address			
<input type="checkbox"/> Add Location <input type="checkbox"/> Change Location <input type="checkbox"/> Remove Location			
<input type="checkbox"/> Same as primary <input type="checkbox"/> Other (Please specify)	Address:		City:      State:      Zip:
	Phone: (   ) -      Ext:	Fax: (   ) -	After Hours: (   ) -      Ext:
Effective Date of Address change: _____			
Pay To Address			
<input type="checkbox"/> Add Location <input type="checkbox"/> Change Location <input type="checkbox"/> Remove Location			
<input type="checkbox"/> Same as primary <input type="checkbox"/> Other (Please specify)	Address:		City:      State:      Zip:
	Phone: (   ) -      Ext:	Fax: (   ) -	After Hours: (   ) -      Ext:
Effective Date of Address change: _____			

## V. PCP AND PHYSICIAN EXTENDERS INFORMATION ONLY

<b>Practice Status:</b>	<input type="checkbox"/> PCP	<input type="checkbox"/> Physician Extender (Applicable to PAs, PAs at Surgery, and NP)	<input type="checkbox"/> Specialist
<b>Preceptor Information</b>	Not Applicable	<b>Full Name</b>	<b>Provider Number</b>
		1.	1.
		2.	2.
		3.	3.
<b>Please enter the maximum number of patients you will accept for the following networks.</b>			
<b>BlueCare®</b>			
<b>TennCareSelect</b>			
<b>BPN</b>			
<b>Total Patients</b>	The three networks listed above can combine to a maximum of 1500 patients.	The three networks listed above can combine to a maximum of 1250 patients.	
<b>Please indicate below what, if any, patient age and gender limitations you have set for your practice.</b>			
<b>Patient Sex:</b>	<input type="checkbox"/> Male Only <input type="checkbox"/> Female Only <input type="checkbox"/> Both Male and Female	<b>Patient Age:</b>	<input type="checkbox"/> Adult only (Ages 18 years and above) <input type="checkbox"/> Pediatric Only (Ages 0-17 years) <input type="checkbox"/> Both Adult and Pediatric (No age limitations)
<b>Other Limitations (Please Specify)</b>			
<b>Please indicate below if any of the services below are offered.</b>			
<input type="checkbox"/> Pre-Natal Care <input type="checkbox"/> Accepts Presumptive Eligibles <input type="checkbox"/> OB Services			

## VI. ADMITTING PRIVILEGES

Do you have admitting privileges with a BlueCross BlueShield of Tennessee network hospital?    Yes    No

List all institutions where you CURRENTLY have clinical privileges.*			
	Primary Institution	Secondary Institution	
<b>Name of Institution:</b>			
<b>Address:</b>	Address:	Address:	
	City:                      State:              Zip:	City:                      State:              Zip:	
<b>Appointment Date:</b>	(mm/yy)	(mm/yy)	
<b>Status:</b>	<input type="checkbox"/> Active/Admitting <input type="checkbox"/> Courtesy <input type="checkbox"/> Other <input type="checkbox"/> Associate <input type="checkbox"/> Provisional	<input type="checkbox"/> Active/Admitting <input type="checkbox"/> Courtesy <input type="checkbox"/> Other <input type="checkbox"/> Associate <input type="checkbox"/> Provisional	

\*This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s).

If you do not hold admitting or clinical privileges List the name(s) of the practitioner(s) who admits your patients.*		
Practitioner Name	Specialty	Phone
1.		(    )    -    Ext
2.		(    )    -    Ext
3.		(    )    -    Ext

\*Admitting or clinical privileges must be provided by a BlueCross BlueShield of Tennessee credentialed practitioner. You must attach a letter on admitting practitioner's letterhead that certifies this practitioner will admit your patients.



BLUECROSS BLUESHIELD OF TENNESSEE AND VOLUNTEER STATE HEALTH PLAN, INC. ATTESTATION

I authorize BlueCross BlueShield of Tennessee, Inc. (BCBST) to consult with hospital administrators, physicians, current and prior malpractice carriers, managed health care plans, IPAs, medical groups and other persons or entities (hereafter collectively referred to as "Persons") to obtain and verify information concerning: my professional competence and conduct, including any pending or closed claims, settlements or judgments against me; character, moral and ethical qualities; and experience in participating in managed care programs (my "Qualifications"). I release BCBST and any such Person and their respective directors, officers, employees, agents or contractors (their "Representative") from any and all liability for any and all acts or omissions arising from or related to the provision, receipt, verification, or evaluation of information pertaining to my Qualifications; except to the extent that such information is knowingly false or misleading and is provided in bad faith or with malice. I acknowledge that my Qualifications shall be evaluated by, or at the direction of BCBST's medical review committee in accordance with TCA 63-6-219.

I represent that the information provided in or attached to this Application and the most current information provided to the selected entities is accurate and complete. I understand that a condition of this Application is that any misrepresentation, misstatement or omission from this Application, whether intentional or not, is cause for automatic and immediate rejection of this Application by the selected entities and may result in denial of my Application or termination of my participation with BCBST. I further understand that any misrepresentation, misstatement or omission from this Application, if discovered after participation has been awarded to me, may lead to immediate suspension or termination of those privileges.

I hereby authorize BCBST to query the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) and further release BCBST from any and all liability arising from querying and reporting to the HIPDB as required by 45 CFR Part 61, except to the extent BCBST has actual knowledge of the falsity of the reported information. I further agree that any dispute relating to or arising in connection with this Application must be resolved in accordance with applicable BCBST policies and procedures.

I consent to such Persons releasing all information and documents that may be relevant to an evaluation of my Qualifications, to BCBST, including, without limitation, information or documents relating to any disciplinary action, suspension or curtailment of my medical license or privileges; and reports or summaries by professional liability insurance carriers or others relating to my insurance coverages, pending and /or closed legal actions, and/or professional liability settlements by or judgments against me. If I have contracted with an IPA, a medical group, physician/hospital organization or similar entity (an "Intermediary"), through which I will participate in BCBST's provider network(s), that Intermediary may disclose all requested information concerning my Qualifications to BCBST. If the Intermediary with whom I have contracted has contracted with another entity to obtain or verify information concerning my Qualifications, that entity and BCBST may consult with and disclose such information to each other.

If any material changes occur with affect my Qualifications, specifically including changes in the information set forth in this application, I agree to immediately notify BCBST of such changes. I understand that I have the burden of providing adequate information to BCBST to demonstrate my Qualifications both now and in the future. I acknowledge that BCBST may, at its sole discretion, decline to contract with me. I agree that any dispute related to or arising in connection with this application must be resolved in accordance with applicable BCBST policies and procedures. This consent shall remain in full force and effect and may be relied on by those Persons and Intermediaries providing information to BCBST until I specifically revoke it in writing. Any such revocation shall not apply retrospectively. A photocopy of this Consent shall be as effective as the original.

No person on the grounds of race, color, religion, national origin, sex, age, or disability shall be excluded form participation in or be subjected to discrimination under any program or service provided by Blue Cross Blue Shield of Tennessee, Inc or Volunteer State Health Plan, Inc.

The undersigned, being hereby warned that intentional or unintentional false statements and the like so made may jeopardize the validity of the Application, declares that he/she is properly authorized to execute this Application; and that all statements made of his/her own knowledge are true; and that all statements made on information and belief are believed to be true.

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Physician Name Only

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Physician Signature Required

\*Please note that original signature is required here. A signature stamp or any other means of signing is unacceptable.

Please fax to: (423) 535-3066 or mail to: **BlueCross BlueShield of Tennessee**  
**Attn: Provider Network Services**  
**PO Box 180176**  
**Chattanooga, TN 37402**