of Tennessee

Provider Change Form

Please check the boxes indicating what you wish to change, and then complete the sections as instructed.

All providers

Adding or changing a Tax ID? Don't use this form. Complete the Provider Enrollment Form.

Change or add a provider specialty or type (PCP/specialist): Complete the online Provider Enrollment Form instead.

Change or add a practice location: Sections 1-3 and the last page

Leaving a group: Sections 1,7 and the last page

Change last name: Section 1 and the last page (licensure information must be updated on the licensure site first)

Change Ecomm vendors or Clearing House contacts: Sections 1, 8, 9 and the last page

PCPs only

Change member information: Sections 1, 5 and the last page

Change your status to "covering only" so members can be moved to another provider: Sections 1, 7 and the last page

When complete, email this form and any attachments to: PNS_GM@bcbst.com

Questions? Call 1-800-924-7141.

First, help us identify you by what we currently have on file:

NPI Name

Name: First Middle Last Suffix Degree (MD, RN, Etc.)

Group NPI Number: Filed Tax ID:

AUTHORIZED INDIVIDUAL INFORMATION (Person completing form)

Authorized Individual's Name Email Address

Phone Number Fax Number

Street Address City State Zip

1. PERSONAL INFORMATION (Only mark what's changing)

Name: First Middle Last Suffix Degree (MD, RN, Etc.)

Gender: M or F Date of Birth: / / NPI Number: Group NPI Number:

Medicare Provider Number: Medicaid Provider Number: State:

State Lic. # DEA # Type of Provider: PCP Specialist Other

Specialty: Primary Language Spoken: Secondary Language Spoken:

Nationality: (Optional)

- Asian
- Asian American
- Alaska Native
- Black (Not Hispanic) or African-American
- Hispanic
- North American Indian
- Pacific Islander
- White (Not Hispanic)
- Other (Please Specify)

Please indicate below what, if any, patient age and gender limitations you have set for your practice.

Patients' Sex:

- Male Only
- Female Only
- Both Male and Female

Patients' Age:

- Adult Only (Ages 18 Years and Above)
- Pediatric Only (Ages 0-17 Years)
- Both Adult and Pediatric (No Age Limitations)

Other Limitations (Please Specify)

Please indicate if any of the services below are offered.

- Pre-Natal Care
- Accepts Presumptive Eligibles
- OB Services

2. PRACTICE LOCATION INFORMATION (Only mark what's changing)

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

Primary Location Information

Practice/Group Name: Pay To: Self Group

Start Date at Location (Required):

Address: City: State: Zip:

Phone (for member appointments): Ext: Fax: After Hours: Ext:

Website Address:

Contact Information:

Name: Title: Phone: Ext:

*Email Address:

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

Office Hours (If this section is left blank, office hours will default to M-F, 8 a.m. to 5 p.m.)

Time Zone	Central Time	Eastern Time	From	To	From	To
Monday	Closed					
Tuesday	Closed	Same as Monday				
Wednesday	Closed	Same as Monday				
Thursday	Closed	Same as Monday				
Friday	Closed	Same as Monday				
Saturday	Closed	Same as Monday				
Sunday	Closed	Same as Monday				

About Your Office	Handicap Accessible?	Offers Handicap Parking?	Offers Transfer Techniques?	Offers Wheelchair-Accessible Exam Room?	Offers Wheelchair-Accessible Exam Table?
	Yes No	Yes No	Yes No	Yes No	Yes No

About Your Office	Hospital-Based Provider?	Offers 24-Hour Coverage?	Concierge Provider?	Covering Only for This Location?	Nursing Home Only?
	Yes No	Yes No	Yes No	Yes No	Yes No

Patient Accepting Status - Medicaid	Patient Accepting Status - Medicare Advantage	Patient Accepting Status - Commercial
New and Existing Existing Only* (*Note: You must be closed to all MCOs.)	New and Existing Existing Only	New and Existing Existing Only

3. ADDITIONAL LOCATION INFORMATION (Only mark what's changing)

Do you need additional locations? Yes No (If more than two, please attach a roster.)

Additional Location Information

Add Location Change Contact Information Remove Location

Address: City: State: Zip:

*Email Address:

Phone: Ext: Fax: Website Address:

Contact Information:

Name: Title: Phone: Ext:

About Your Office	Handicap Accessible?	Offers Handicap Parking?	Offers Transfer Techniques?	Offers Wheelchair-Accessible Exam Room?	Offers Wheelchair-Accessible Exam Table?
	Yes No	Yes No	Yes No	Yes No	Yes No

About Your Office	Hospital-Based Provider?	Offers 24-Hour Coverage?	Concierge Provider?	Covering Only for This Location?	Nursing Home Only?
	Yes No	Yes No	Yes No	Yes No	Yes No

Additional Location Information

Add Location Change Contact Information Remove Location

Address: City: State: Zip:

*Email Address:

Phone: Ext: Fax: Website Address:

Contact Information:

Name: Title: Phone: Ext:

About Your Office	Handicap Accessible?	Offers Handicap Parking?	Offers Transfer Techniques?	Offers Wheelchair-Accessible Exam Room?	Offers Wheelchair-Accessible Exam Table?
	Yes No	Yes No	Yes No	Yes No	Yes No

About Your Office	Hospital-Based Provider?	Offers 24-Hour Coverage?	Concierge Provider?	Covering Only for This Location?	Nursing Home Only?
	Yes No	Yes No	Yes No	Yes No	Yes No

4. CONTRACT NOTICE ADDRESS (Only mark what's changing)

Mailing Address

Add Location Change Contact Information Remove Location Same as Primary Listed in Section 2 Other (Please Specify)

Address: City: State: Zip:

Email Address:

Phone: Ext: Fax: Website Address:

Effective Date of Address Change:

Corporate Address (This is where we'll send your contract.)

Add Location Change Contact Information Remove Location Same as Primary Listed in Section 2 Other (Please Specify)

Address: City: State: Zip:

Email Address: (This will be used for Provider Stability Act notifications.)

Phone: Ext: Fax: Website Address:

Effective Date of Address Change:

Pay to Address (This is used only when Electronic Funds Transfer is not available.)

Add Location Change Contact Information Remove Location Same as Primary Listed in Section 2 Other (Please Specify)

Address: City: State: Zip:

Email Address:

Phone: Ext: Fax: Website Address:

Effective Date of Address Change:

5. PCP'S AND PHYSICIAN EXTENDER'S INFORMATION (Only mark what's changing)

Practice Status:	PCP	Physician Extender (Applicable to PAs, PAs at Surgery, and NP)		Specialist
Preceptor Information:	Not Applicable	Full Name	Provider Number	
		1.	1.	
		2.	2.	
		3.	3.	
Please enter the maximum number of patients you will accept for the following networks.				
BlueCare				
TennCare*Select*				
BPN				
Select Community				
Total Patients	The networks listed above can combine to a maximum of 2,500 patients.	The networks listed above can combine to a maximum of 1,250 patients.		

Please indicate below what, if any, patient age and gender limitations you have set for your practice.

Patients' Sex:	Male Only Female Only Both Male and Female	Patients' Age:	Adult Only (Ages 18 Years and Above) Pediatric Only (Ages 0-17 Years) Both Adult and Pediatric (No Age Limitations)

Other Limitations (Please Specify)

Please indicate if any of the services below are offered.

Pre-Natal Care Accepts Presumptive Eligibles OB Services

6. HOSPITAL PRIVILEGES (Only mark what's changing)

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

Are you adding institutions where you have clinical privileges?*

	Primary Institution			Secondary Institution		
Name of Institution:						
Address:	Address:			Address:		
	City:	State:	Zip:	City:	State:	Zip:
Appointment Date:	(mm/yy)			(mm/yy)		
Privilege Status: (See definitions below)	Active/ Admitting	Courtesy	Other	Active/ Admitting	Courtesy	Other
	Associate	Provisional		Associate	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 any practitioners who admit 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.

Please provide the full name and BlueCross provider or NPI number of your covering physician(s).

If you need additional space, please list providers on a separate sheet and attach.

On-Call Provider Name	BlueCross Provider Number	NPI	BlueCross Networks

Are you removing institutions where you have clinical privileges?*

	Primary Institution				Secondary Institution			
Name of Institution:								
Address:	Address:				Address:			
	City:		State:	Zip:	City:		State:	Zip:
Appointment Date:	(mm/yy)				(mm/yy)			
Privilege Status: (See definitions below)	Active/ Admitting	Courtesy	Other		Active/ Admitting	Courtesy	Other	
	Associate	Provisional			Associate	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 any practitioners who admit 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.

Please provide the full name and BlueCross provider or NPI number of your covering physician(s).

If you need additional space, please list providers on a separate sheet and attach.

On-Call Provider Name	BlueCross Provider Number	NPI	BlueCross Networks

Reason for Leaving: (Select One Option Below)

Moved out of State	Tax Change	Retired
Deceased	No Longer Practice at This Location	Other:

Effective date of reason listed above:

7. PROVIDER LEAVING PRACTICE/GROUP (Only mark what's changing)

Primary Care Physician

Please advise how to transition any members currently assigned to you.

(Please note Members can only be transitioned to a new location that provides access to care within 30 miles or 30 minutes' travel time.)

Automatically Assign to Another BlueCare Tennessee Provider		
Transfer members to my other location.	BlueCross Provider # NPI # Tax ID	Address City State Zip
Assign my members to the following provider number(s).	BlueCross Provider # NPI # Tax ID	Address City State Zip
Must be a participating Primary Care provider in the BlueCross or BlueCare Tennessee network in which members are assigned.	BlueCross Provider # NPI # Tax ID	Address City State Zip
	BlueCross Provider # NPI # Tax ID	Address City State Zip

The current PCP must sign this form indicating authorization to reassign members.

Current PCP Date

In order for a member to be transferred to a specific PCP, the PCP agreeing to accept the member must sign below.

PCP Agreeing to Accept Members Date

If the provider has left and there is no forwarding information to contact the provider, the Office Manager can authorize the transition of members by signing below:

Office Manager Date

8. ECOMMERCE CONTACT INFORMATION (Only mark what's changing)

eCommerce Contact Name	eCommerce Email Address (Required)
Phone Number	Fax Number

9. CLAIM SUBMISSION INFORMATION (Only mark what's changing)

Who will submit your claims (Select one)	Select ONE option and include all applicable information. (If you are unsure of the submitter's identification number, verify this information with your vendor before completing.)			
Filing Direct with Purchased Software or In-House Software	Software Company Name			
	Submitter Identification Number		Phone Number	Ext.
	List existing mailboxes if associated with a group. (Ex: UBAAA.X12, PTAAA.X12, ECAAA.X12)			
	Reports Mailbox Name		Remits Mailbox Name	
Filing with Third Party/Billing Agent	Provide information only for the agency that submits claims to BlueCross BlueShield of Tennessee.			
	Billing Agent / Clearinghouse Name			
	Billing Contact		Phone Number	Ext.
	Third Party Submitter Identification Number (Required)			
	Street	City	State	Zip

Retrieval of Remits/Reports through Secure File Gateway (SFG)	
Claims Acknowledgement (277CA)**	277CA reports will be routed to the claims submitter. **NOTE: If a third party submits your claims, the third party will receive the 277CA Reports.

Electronic Remittance Advice (835)

BlueCross BlueShield of Tennessee is pleased to participate in EnrollHub™, a CAQH Solution™ that allows providers to enroll in electronic funds transfer (EFT) and electronic remittance advice (ERA) with multiple payers through a single online process at no cost to the provider.

EnrollHub facilitates compliance with the 2014 EFT/ERA mandate under the Affordable Care Act, eliminates administrative redundancies and creates significant time and cost savings.

Visit https://solutions.caqh.org to sign up today.

Please confirm that you have completed EFT/ERA enrollment via EnrollHub OR you are joining an existing group that already has EFT/ERA established.
Your application is not complete without EFT/ERA enrollment.

I agree.

Additional ANSI Transactions		
270 Eligibility	276 Claim Inquiry	Please contact the eBusiness Service Center at (423) 535-5717 or e-mail: eBusiness_service@BCBST.com for Technical Support assistance.
Note: It is the provider's responsibility to obtain and review all electronic reports to ensure proper receipt of claims by BlueCross BlueShield of Tennessee. An electronic control number (ECTN) is issued for each EDI claim received and serves as the receipt confirmation. ANSI Format Testing information, Companion Guides, Edit Listings, Secure File Gateway System Information, and the HIPAA Compliance Self-Testing Web Tool are available on BlueCross BlueShield of Tennessee's website at: http://www.bcbst.com/providers/ecomm/HIPAA/CertTestDetails.pdf, http://www.bcbst.com/providers/ebusiness/technical-information.page and http://www.bcbst.com/providers/ecomm/HIPAA/ANSI_SelfTestingProc.pdf		

Additional ANSI Transactions

The client sending and receiving data will:

- Maintain adequate security procedures to prevent unauthorized access to data, data transmissions, security access codes, backup files or source documents;
- Maintain complete accurate and unaltered copies of all Source Documents from all Data Transmissions for no less than six (6) years;
- Provide information, documents and other cooperation necessary to assist BlueCross BlueShield of Tennessee in research as it pertains to problem resolution;
- Hold BlueCross BlueShield of Tennessee harmless from any and all claims, actions, damages, liabilities, cost, or expenses, including, without limitation, reasonable attorneys' fees, arising out of any act or omission of performance by the provider, provider's employees or business associates;
- Understand it is the provider's responsibility to obtain and review all electronic reports to ensure proper receipt of claims by BlueCross BlueShield of Tennessee (An electronic control number is issued for each EDI claim received and serves as the receipt confirmation);
- Understand it is the provider and submitter's responsibility to retrieve the BlueCross BlueShield of Tennessee 277CA files and review them for any claims rejections needing to be corrected and resubmitted; and
- Understand that any assigned individual User IDs should not be shared, and should be used only by that individual.

HTTPS Protocol (Individual Account) should not be hardcoded into any system or script.

The Provider's User ID and password serve as their electronic signature, and the provider will be liable for improper sharing including any illegal acts when using the password. User IDs and passwords are not part of the provider's capital property and should not be given to the new owner of that operation. A new owner must obtain their own User ID and password.

CERTIFICATION OF PROFESSIONAL HISTORY AND PROVIDER RESPONSIBILITIES

As a condition of my participation in any BlueCross BlueShield of Tennessee product network, I agree to maintain general liability insurance coverage with reasonable limits and workers' compensation insurance coverage in accordance with applicable state law. I agree to maintain that coverage continuously while participating in any BlueCross BlueShield of Tennessee product network, and will provide acceptable proof of coverage to BlueCross upon request.

I, the undersigned practitioner, certify that the above and any additional information provided is complete, accurate, and true. I acknowledge that falsification, inaccuracy, or failure to fully disclose any information requested is grounds for rejection of practitioner's application for any BlueCross Provider Networks. I hereby authorize BlueCross BlueShield of Tennessee to query the National Practitioner Data Bank (NPDB) and further release BlueCross from any and all liability arising from querying and reporting to the HIPDB as required by 45 CFR Part 61, except to the extent BlueCross 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 BlueCross BlueShield of Tennessee policies and procedures.

Signature　　　　　　　　　　　　　　　　Date

Email to: PNS_GM@bcbst.com