Change in Provider Information—Professional Providers Only

CareFirst
Family of health care plans

INSTRUCTIONS

Provider information changes and attestations should be completed electronically using the Provider Updates & Attestation self-service tool within the CareFirst Provider Portal. If you need assistance using the tool, access these **step-by-step instructions**.

If you are unable to submit changes electronically, use this form and send, along with your letterhead, to Mail Administrator, P.O. Box 14763, Lexington, KY 40512.

◯ Check here if you are attesting your data is accurate and no changes are needed.

GENERAL INFORMATION

Office Contact		Phone #	Date
Practice Name		Practice NPI	Tax ID
Provider Name	Provider NPI	Provider #	

ADDRESS OR PHONE NUMBER CHANGE

Check all boxes that apply for the type of change and specify what is changing.

Change 1			Change 2		
Type of Change ◯ Add New ◯ Cancel ◯ Change	What's Changing ◯ Office ◯ Directory ◯ Mailing ◯ Tax ◯ Payee/billing/vendor	Effective Date of Change	Type of Change ◯ Add New ◯ Cancel ◯ Change	What's Changing ◯ Office ◯ Directory ◯ Mailing ◯ Tax ◯ Payee/billing/vendor	Effective Date of Change
New Address			New Address		
New Phone #	New Fax #		New Phone #	New Fax #	
Is the Provider a Primary Care Physician (Family Practitioner, Internist, Pediatrician)? ◯ Yes ◯ No			Is the Provider a Primary Care Physician (Family Practitioner, Internist, Pediatrician)? ◯ Yes ◯ No		
Is this a new office location? ◯ Yes ◯ No If Yes, attach a list of providers at this location			Is this a new office location? ◯ Yes ◯ No If Yes, attach a list of providers at this location		

NAME CHANGE

For an individual name change, attach copy of marriage license, divorce decree, etc.

Previous Name	New Name	Effective Date of Change

TAX ID (ATTACH W9) OR BILLING NPI CHANGE

Previous Tax ID or Billing NPI	New Tax ID	Effective Date of Change
Current Billing NPI	New Billing NPI	Effective Date of Change

PROVIDER LEAVING PRACTICE

If joining an existing practice, access the Provider Updates and Attestation self-service tool within the **CareFirst Provider Portal** (see step-by-step instructions above for assistance).

If establishing a new practice, go to the **How to Apply page** and complete the steps indicated.

Provider Name	Effective Date of Change

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield Medicare Advantage is the shared business name of CareFirst Advantage PPO, Inc. and CareFirst Advantage DSNP, Inc. CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. CareFirst BlueCross BlueShield Community Health Plan District of Columbia is the business name of Trusted Health Plan (District of Columbia), Inc. CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst Advantage PPO, Inc., CareFirst Advantage DSNP, Inc., CareFirst Community Partners, Inc., CareFirst BlueCross BlueShield Community Health Plan District of Columbia, First Care, Inc., and The Dental Network, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

PROVIDER LEAVING PRACTICE

Reason for Leaving

◯ Leaving Service Area ◯ Retired ◯ Deceased ◯ Joining Another Practice ◯ Other_____

OPEN/CLOSE PANEL

Provider Name

BlueChoice/HMO Panel ◯ Open Panel ◯ Closed Panel BluePreferred/PPO Panel ◯ Open Panel ◯ Closed Panel

Reason

SPECIALTY CHANGE

Previous Specialty	New Specialty

Is Provider board-certified in this specialty?

◯ Yes ◯ No If Yes, attach a copy of board certification.

AUTHORIZED SIGNATURE

Person authorized to make change (Print Name)	Email	
Signature	Title	Date

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