

Provider Reimbursement/Change Form

614 Market Square, PO Box 1948, Parkersburg, WV 26102

Instructions: The information requested below is required by Highmark Blue Cross Blue Shield West Virginia for the proper issuance of payments/Provider Explanation of Benefits (EOB) and other related information to your practice/group/billing address. (**Note**: This information must be consistent with the information provided in blocks 24, 25, 31 and 33 when billing for your services on the CMS 1500 claim form.) Please return this form with your signed Agreement(s) to Highmark Blue Cross Blue Shield West Virginia, attention Provider Maintenance.

Please use this form to identify changes in your locations, Tax ID or practice arrangement. Return this form with your signed Network Agreement to Highmark Blue Cross Blue Shield West Virginia, attention Provider Maintenance.

Please complete one Provider Reimbursement/Change Form per Tax ID. (Please refer to back of form if additional space is needed.)

New Provider or Add to Staff Information Tax Identification Number				Organizational NPI (Type 2)						
Practice Name				tive Date		Check Appropriate Box ☐ Individual /Sole proprietor ☐ Corporatio ☐ Partnership ☐ Other				
Street Address of Prima	ry Office					Telephone				
City State			Coun	ty		Zip	Office Fax Number			
Reimbursement Name	(Attach Copy of	W-9)		Reimbu	rsement Addre	ess	1			
City		State	County			Zip	Telephone			
Please provide office hours for each day	-		Wedn	Wednesday Thursday		Friday	Saturday Sun			
Do you provide 24-hour coverage?					Describe Coverage					
	☐ YES ☐ NO	□ N/A					-			
Do you have an answering service/machine?						our answering service/machine available all times when you are not in the office?				
	☐ YES ☐ NO	□ N/A			□ YES □ NO □ N/A					
List b	elow other afte	r-hours arranger	nents or s	special in	structions to	patients for afte	er-hours care need:			
Changes										
☐ Practice Name Change – Group										
From:				To:						
Effective Date:			Indicate w	hich loca	ition this chang	je applies to:				
□ Provider Name Chan	ae – Individual		1							
☐ Provider Name Change – Individual				From:						
Effective Date:				То:						
☐ Address Change – Fr	om:			To:						
Effective Date:										
Practice Name:				Practice Name:						
Old Address:				New Address:						
City, State, Zip:				City, State, Zip:						
☐ Tax ID Change:										
-				Old Number:						
Effective Date:				Now Number						

Cancellations Provider Number Cancellation:				: (please incl	ude dates in fie	ld provided	1)				
Tax ID & Suffix:				Reason: (please include dates in field provided)							
				Effective Date:							
Practice Location:				□ No longer here							
Name:				☐ Retired							
Address:				□ Deceased							
City, State, Zip:			Oth	Other							
lf addi	tional space is	needed ple	ase copy and atta	ch to Provid	er Reimbursei	ment/Char	ige Form				
Additional provi		tion unde					_				
1. Individual Provide	er Name		Individual NPI (Type	e 1) *	Primary Specia	alty	Effective Date				
Street Address		Telephone		Practice locations listed belo		ow (Check appropriate b					
City	y State		County		(ip	Office Fax	Number				
* If your Primary Specia Care Physician?	Ity is Internal M	edicine, Pedi	atrics, General Prac	tice or Family	Practice, do yo	u want to b	e represen	ted as a Prin			
Individual Provider Name			Individual NPI (Type	e 1) *	* Primary Specialty		Effective Date				
Street Address			Telephone		Practice locations listed below (Check appropriation B. B. C. D. D.						
City		State	County		<u>к. ш. в. ш. с.</u> Ир	Office Fax Number					
* If your Primary Specia		edicine, Pedi	atrics, General Prac	tice or Family	Practice, do yo	u want to b	e represen	ted as a Prin			
Care Physician?	er Name		Individual NPI (Type	e 1) *	* Primary Specialty E			Date			
Street Address			Telephone	F	Practice locations listed below (Check appropri						
City		State	County	A	A. B. C. D. D. Zip Office Fax Numb						
			,								
* If your Primary Specia Care Physician? 		edicine, Pedi	atrics, General Prac	tice or Family	Practice , do yo	ou want to b	e represen	ted as a Prin			
^	:f	.:	sama Tav ID a	nd Daimh	N.						
Additional locati A. Practice Name	on informat	ion under	same lax ID a	na Keimbi	Effective Date	ame					
Street Address					Telephone						
					7in	Number					
Citv		State	County		LLID						
	Monday	State	County	Thursday	Zip	Sa	turday	Sunday			
Please provide office	Monday	State Tuesday	County Wednesday	Thursday		Sa	turday	Sunday			
Please provide office hours for each day	Monday I provide 24-ho	Tuesday	Wednesday	Thursday	Friday	Sa be Coverag		Sunday			
Please provide office hours for each day Do you		Tuesday ur coverage?	Wednesday	Thursday	Friday			Sunday			
Please provide office nours for each day Do you	ı provide 24-ho	Tuesday ur coverage?	Wednesday	ls	Friday Descri	ibe Coverag	e hine availal	ole			
Please provide office hours for each day Do you Do you	ı provide 24-ho □ YES □ NO	Tuesday ur coverage? N/A service/machi	Wednesday	ls	Priday Descri	ibe Coverag	ne hine availal in the office	ole			
Do you ha	yes NO YES NO	Tuesday ur coverage? N/A service/machi	Wednesday	ls: a	Pescri Descri your answering s t all times when	service/macl you are not	nine availal in the office	ole			
Please provide office hours for each day Do you	yes NO YES NO	Tuesday ur coverage? N/A service/machi	Wednesday ne?	ls: a	Pescri Descri your answering s t all times when	service/macl you are not	nine availal in the office	ole			

Signature – Provider or group legal representative

Date