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			Effective Date		**Check Appropriate Box** ❑ Individual /Sole proprietor ❑ Corporation ❑ Partnership ❑ Other		
Street Address of Primary Office					Telephone		
City	State		County		Zip	Office Fax Number	
Reimbursement Name **(Attach Copy of W-9)**			Reimbursement Address				
City	State		County		Zip	Telephone	
Please provide office hours for each day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Do you provide 24-hour coverage?	**Describe Coverage**
❑ YES ❑ NO ❑ N/A	
Do you have an answering service/machine?	Is your answering service/machine available at all times when you are not in the office?
❑ YES ❑ NO ❑ N/A	❑ YES ❑ NO ❑ N/A
List below other after-hours arrangements or special instructions to patients for after-hours care need:	

Changes

❑ Practice Name Change – Group From:	To:
Effective Date: _____ Indicate which location this change applies to: _____	

❑ Provider Name Change – Individual Effective Date: _____	From: _____ To: _____

❑ Address Change – From: Effective Date: _____ Practice Name: _____ Old Address: _____ City, State, Zip: _____	To: Practice Name: _____ New Address: _____ City, State, Zip: _____

❑ Tax ID Change: Effective Date: _____	Old Number: _____ New Number: _____

(R08-11)

Cancellations

Provider Number Cancellation:	**Reason: (please include dates in field provided)**
Tax ID & Suffix: _____	Effective Date: _____
Practice Location: _____	❑ No longer here _____
Name: _____	❑ Retired _____
Address:_____	❑ Deceased _____
City, State, Zip: _____	❑ Other_____

If additional space is needed please copy and attach to Provider Reimbursement/Change Form.

Additional provider information under same Tax ID

1. Individual Provider Name		Individual NPI (Type 1)	*** Primary Specialty**	Effective Date
Street Address		Telephone	Practice locations listed below (Check appropriate box) A. ❑ B. ❑ C. ❑ D. ❑	
City	State	County	Zip	Office Fax Number

***** If your Primary Specialty is **Internal Medicine, Pediatrics, General Practice** or **Family Practice**, do you want to be represented as a Primary Care Physician? ❑ **YES** ❑ **NO**

2. Individual Provider Name		Individual NPI (Type 1)	*** Primary Specialty**	Effective Date
Street Address		Telephone	Practice locations listed below (Check appropriate box) A. ❑ B. ❑ C. ❑ D. ❑	
City	State	County	Zip	Office Fax Number

***** If your Primary Specialty is **Internal Medicine, Pediatrics, General Practice** or **Family Practice**, do you want to be represented as a Primary Care Physician? ❑ **YES** ❑ **NO**

3. Individual Provider Name		Individual NPI (Type 1)	*** Primary Specialty**	Effective Date
Street Address		Telephone	Practice locations listed below (Check appropriate box) A. ❑ B. ❑ C. ❑ D. ❑	
City	State	County	Zip	Office Fax Number

***** If your Primary Specialty is **Internal Medicine, Pediatrics, General Practice** or **Family Practice**, do you want to be represented as a Primary Care Physician? ❑ **YES** ❑ **NO**

Additional location information under same Tax ID and Reimbursement Name

A. Practice Name				Effective Date	
Street Address				Telephone	
City	State	County		Zip	Office Fax Number

Please provide office hours for each day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Do you provide 24-hour coverage?	**Describe Coverage**
❑ YES ❑ NO ❑ N/A	
Do you have an answering service/machine?	Is your answering service/machine available at all times when you are not in the office?
❑ YES ❑ NO ❑ N/A	❑ YES ❑ NO ❑ N/A
List below other after-hours arrangements or special instructions to patients for after-hours care need:	

_____ _____

Signature – Provider or group legal representative Date