Blue Cross and Blue Shield of Minnesota
Provider Demographic Change Form
Fax to: (651) 662-6684 or
Mail to: BCBSMN PDO, R316
P.O. Box 64560
St. Paul, MN 55164-0560

Please complete this form when changing an address, phone number, hospital affiliation, or office hours. If the information being changed pertains to more than one location, please complete a separate form for each location. **Please include all clinic NPI numbers that the change applies to.** If sending notification of a Tax ID change, please complete the Tax Identification Change Form.

If you have any questions, please call us at (651) 662-5200 or 1-800-262-0820

Tax ID #: **Effective Date of Change**

Old Information:

Legal Name:

Doing Business As (DBA): NPI/UMPI #:

Physical Address	**Mailing Address**	**Billing Address**
Address:	Address:	Address:
City: St: Zip:	City: St: Zip:	City: St: Zip:
Phone #:		Phone #:
Referral Fax: (TRICARE only)		

New Information:

Legal Name:

Doing Business As (DBA): NPI/UMPI #:

Physical Address ☐ Unchanged	**Mailing Address** ☐ Unchanged (only complete if you aren't able to accept mail at your physical location)	**Billing Address** ☐ Unchanged
Name:	Name:	Name:
Address:	Address:	Address:
City: St: Zip:	City: St: Zip:	City: St: Zip:
Phone #:		Phone #:
Referral Fax: (TRICARE only)		

Can you accept mail at this location: Directory Suppressed:

Accepting New Patients*: (Please notify BCBSMN if this changes)

Urgent Care: (If yes, please complete Urgent Care hours below)

*If there are any practitioners at this location that aren't accepting new patients, please attach additional documentation.

Hospital Affiliations:

Address: City: St: Zip:

	Open (Mon) Close	**Open (Tues) Close**	**Open (Wed) Close**	**Open (Thur) Close**
Regular				
Urgent Care				

	(Fri)	**(Sat)**	**(Sun)**
Regular			
Urgent Care			

Person Completing Form:

Digital Signature: Phone #:

E-Mail Address: Fax #:

Submit by Email **Print**

The Sender of this Form represents and warrants that he/she is authorized to submit these changes on behalf of the Provider.