CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.
Provider Information and Credentialing
Mailstop CG-41
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Owings Mills, MD 21117-0825

Phone: 410-872-3500
Toll Free: 877-269-9593
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Change in Provider Information

INSTRUCTIONS: Use this form to report provider information changes.
Send this form along with your letterhead to the address or fax number above.

GENERAL INFORMATION

Office Contact:	Phone Number:	Date: / /
Practice Name:	Tax ID:	

Provider Name:	Social Security Number:	Provider Number:	National Provider Identifier:

ADDRESS OR PHONE NUMBER CHANGE – Check all boxes that apply for the type of change

Add New	Cancel	Change	Effective Date:	Add New	Cancel	Change	Effective Date:
❑	❑	❑	/ /	❑	❑	❑	/ /

TYPE OF CHANGE					TYPE OF CHANGE				
Office ❑	Mailing ❑	Payee/Billing/Vendor ❑	Directory ❑	Tax ❑	Office ❑	Mailing ❑	Payee/Billing/Vendor ❑	Directory ❑	Tax ❑

Address 1:	Address 1:
Address 2:	Address 2:
City: State: Zip:	City: State: Zip:
Phone Number: Fax Number:	Phone Number: Fax:

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

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

Previous Name:	New Name:	Effective Date: / /

TAX ID CHANGE – Attach billing authorization form or W9 for each provider

Previous Tax ID:	New Name:	Effective Date: / /

PROVIDER LEAVING PRACTICE – If joining a new practice, submit uniform credentialing form

Provider Name:	Effective Date: / /

Reason for Leaving:	Leaving Service Area ❑	Deceased ❑	Retired ❑	Joining Another Practice ❑	Other:

Check One: Open Panel ❑ Closed Panel ❑

Provider Name:

Reason:	Effective Date: / /

SPECIALITY 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):

Signature:	Title:	Date: / /

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