blue california | Provider Connection

Blue Shield of California Provider Demographic Information Update Form

INSTRUCTIONS

- Type or use black pen.
- Fill both current (on file at Blue Shield of California) and updated demographic information.
- Print your name, sign and date the form, and have an authorized representative of your business (physician, owner, officer) sign it.
- Email the completed form and any required documentation to **BSCProviderInfo@blueshieldca.com** or mail to:

  Blue Shield of California Provider Services
  P.O. Box 629017,
  El Dorado Hills, CA 95762-9017

*Changes to a tax ID, billing address, or location require documentation. Contact our Provider Services at **(800) 258-3091** for guidance.

PROVIDER CONTACT INFORMATION

Provider name: _____

Tax ID for claim processing*: _____ **Blue Shield PIN:** _____

Billing address*: _____

Contact name: _____

Contact email: _____

Contact phone(s): _____ ☐ Office ☐ Mobile _____ ☐ Office ☐ Mobile

ATTACHMENTS INCLUDED

☐ **NPI form** ☐ **Tax ID documentation** ☐ **Other** _____

_____

_____

_____

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PROVIDER DETAILS

	Current information	Updated information
Provider name:	_____	_____
	_____	_____
National Provider ID:	_____	_____
Provider type: (select one)	☐ Practitioner ☐ Facility ☐ IPA/Medical group ☐ Other	☐ Practitioner ☐ Facility ☐ IPA/Medical group ☐ Other
Primary specialty:	_____	_____
Other specialties: (up to 5)	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
Accepting new patients:	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Areas of special expertise:	☐ Blindness/visual impairment ☐ Chronic illness ☐ Co-occurring disorders ☐ Deafness/hearing loss ☐ HIV/AIDS ☐ Homelessness ☐ Physical disability ☐ Serious mental illness ☐ N/A	☐ Blindness/visual impairment ☐ Chronic illness ☐ Co-occurring disorders ☐ Deafness/hearing loss ☐ HIV/AIDS ☐ Homelessness ☐ Physical disability ☐ Serious mental illness ☐ N/A
Telehealth visits:	☐ Available ☐ Not available ☐ N/A	☐ Available ☐ Not available ☐ N/A

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LOCATION DETAILS

	Current information	Updated information
Physical address*		
Street address 1:		
Street address 2:		
City:		
State:		
Zip code:		
Phone:		
Fax:		
Email address:		
Wheelchair access:	☐ Accessible ☐ Not accessible	☐ Accessible ☐ Not accessible
Office hours (from - to)		
Monday:	_____ – _____	_____ – _____
Tuesday:	_____ – _____	_____ – _____
Wednesday:	_____ – _____	_____ – _____
Thursday:	_____ – _____	_____ – _____
Friday:	_____ – _____	_____ – _____
Saturday:	_____ – _____	_____ – _____
Sunday:	_____ – _____	_____ – _____

LANGUAGES

	Current information	Updated information
Clinical staff languages: (up to 5)		
Medical interpreter languages:	☐ Cantonese ☐ Korean ☐ Mandarin ☐ Russian ☐ Spanish ☐ Vietnamese	☐ Cantonese ☐ Korean ☐ Mandarin ☐ Russian ☐ Spanish ☐ Vietnamese

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NOTES (OPTIONAL)

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_____

_____

ACKNOWLEDGEMENT (REQUIRED)

Completed by:

Name (PRINT): _____

Signature: _____ **Date:** _____

Authorized by provider (physician/practitioner or owner/ officer for facilities and groups):

Name (PRINT): _____

Signature: _____ **Date:** _____