

Change of Information Form



ND

Provider Information

Provider or Facility/Clinic Name		
NPI (include both new and old NPIs if there is a change)	Tax ID (include both new and old Tax IDs if there is a change)	
Address		
City	State	Zip

Requestor Contact Information

Requestor Contact Name	Phone
Fax	Email

Update Information

Information to be updated:

<input type="checkbox"/> 1099 Address	<input type="checkbox"/> Tax ID
<input type="checkbox"/> Clinic/Practicing Address	<input type="checkbox"/> Provider Name Change (<i>Ex. Marriage</i>)
<input type="checkbox"/> Mailing Address	<input type="checkbox"/> Appointment Phone Number
<input type="checkbox"/> Check Address	<input type="checkbox"/> Accepting New Patients
<input type="checkbox"/> Clinic/Practice Name	

Please detail the information to be updated in the space provided below.

SUBMIT INSTRUCTIONS

If you are having difficulty submitting the form once completed, please send using one of the following methods:

- Email (Please follow these steps):
 - Click on 'File' at the top of your screen
 - Click on 'Save As'
 - Save the completed form on your computer
 - Attach the completed form to an email and send to providerforms@bcbsnd.com
- Fax: 701-282-1910
- Mail: 4510 13th Ave S
Fargo, ND 58121