Directory Maintenance Form

Blue Cross Blue Shield of North Dakota (BCBSND) is required to conduct provider outreach to ensure that our directory is current and displaying accurate information for our members, your patients. If you received a letter in the mail directing you to this form, please list the billing NPI that was in the upper right-hand corner of the letter, then complete the red required fields and any applicable fields that follow.

If a list of practitioners was included with your letter, please verify and submit a New Location Request Form for anyone missing from that list. Organizations who do not bill for performing practitioners would only receive information pertaining to the business, according to what we have on file.

If you bill using more than one NPI, please complete a separate form per billing NPI. Also, if space is too limited, attachments are acceptable. Red fields are required for processing.

Business Information

Credentialing Contact Information

Business Name			NPI
Telemedicine Services? ☐ Yes ☐ No			
Practice Address			
City		State	Zip
Appointment Phone	Fax	Website URL	
Contact Name		Title	
Mailing Address			
City		State	Zip
Phone	Fax	Email	

Is any of the following information in need of update?

- Handicap accessibility
- Languages spoken in office (appointment desk)
- Business/location closures or physical address changes
- Providers in your clinic retired or terminated employment
- New patient or patient age range acceptance

☐ **Yes** ***(Please complete the applicable sections on the following pages.)***

☐ **No** ***(Please submit form as directed on Page 3 of this form.)***

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Directory Information

Is your location handicap accessible? ☐ Yes ☐ No

If yes, what kind of accessibility procedures are in place?

What languages, other than English, are fluently spoken within your organization?

Address Changes

Old Practice Address

Building Name		
Address		
City	State	Zip

New Practice Address *(If there are other address changes such as mailing, check, lock box, credentialing or 1099 tax forms, please describe in an attachment)*

Building Name		
Address		
City	State	Zip

Practice Information

Terminated Practitioners *(Names of all practitioners listed in the attached document who are no longer practicing at your organization (retired, termed employment, etc.) and the effective date)*

Practitioner Name	Reason	Date
Practitioner Name	Reason	Date
Practitioner Name	Reason	Date
Practitioner Name	Reason	Date
Practitioner Name	Reason	Date

New Patient Acceptance *(Names of all practitioners who are* ***NOT*** *currently accepting new patients)*
Practitioner Name
Practitioner Name
Practitioner Name
Practitioner Name
Practitioner Name

Patient Age Restrictions *(Please list all practitioners who have patient age restrictions)*	
Practitioner Name	Restriction
Practitioner Name	Restriction
Practitioner Name	Restriction
Practitioner Name	Restriction
Practitioner Name	Restriction

Practice Information *(Continued)*

Hospital Admitting Privileges *(Please list all practitioners who have hospital admitting privileges)*		
Practitioner Name	Hospital	Date
Practitioner Name	Hospital	Date
Practitioner Name	Hospital	Date
Practitioner Name	Hospital	Date
Practitioner Name	Hospital	Date
Practitioner Name	Hospital	Date

Tax ID Changes

Have there been any changes of tax ID in the last 12 months? ☐ Yes ☐ No

If yes, was debt and liability assumed by the new tax ID? Please describe and include date(s) below.

Completed forms can be returned by:

- Email: providerforms@bcbsnd.com
- Mail: Blue Cross Blue Shield of North Dakota
  Attn: Credentialing & Data Management
  4510 13th Avenue South
  Fargo, ND 58121

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