Change in Provider Information—Professional Providers Only

CareFirst
Family of health care plans

INSTRUCTIONS

Use this form to report provider information changes, or update at www.carefirst.com/carefirstdirect. Send this form along with your letterhead to Mail Administrator, P.O. Box 14763, Lexington, KY 40512, or fax to 410-872-4107.

◯ Check here to indicate that there are no changes at this time.

GENERAL INFORMATION

Office Contact		Phone #	Date
Practice Name		Tax ID	
Provider Name	Social Security #	Provider #	National Provider Identifier

ADDRESS OR PHONE NUMBER CHANGE

Check all boxes that apply for the type of change and specify what is changing.

Change 1			Change 2		
Type of Change ◯ Add New ◯ Cancel ◯ Change	What's Changing ◯ Office ◯ Directory ◯ Mailing ◯ Tax ◯ Payee/billing/vendor	Effective Date of Change	Type of Change ◯ Add New ◯ Cancel ◯ Change	What's Changing ◯ Office ◯ Directory ◯ Mailing ◯ Tax ◯ Payee/billing/vendor	Effective Date of Change
New Address			New Address		
New Phone #	New Fax #		New Phone #	New Fax #	
Is the Provider a Primary Care Physician (Family Practitioner, Internist, Pediatrician)? ◯ Yes ◯ No			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			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 W9)

Previous Tax ID	New Tax ID	Effective Date

PROVIDER LEAVING PRACTICE

If joining a new practice, submit uniform credentialing form.

Provider Name	Effective Date

Reason for Leaving

◯ Leaving Service Area ◯ Retired ◯ Deceased ◯ Joining Another Practice ◯ Other_____

CUT6189-1N (7/18)

OPEN/CLOSE PANEL

Provider Name

BlueChoice/HMO Panel ◯ Open Panel ◯ Closed Panel BluePreferred/PPO Panel ◯ Open Panel ◯ Closed Panel

Reason

SPECIALTY 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)	Email	
Signature	Title	Date