WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

PRACTICE/OFFICE INFORMATION FORM

INDIVIDUAL PROVIDER INFORMATION

Enter the information of the specific provider that will be added to this clinic

PROVIDER NAME (FIRST MI LAST, TITLE)	GENDER	SOCIAL SECURITY NUMBER
INDIVIDUAL (TYPE 1) NPI	DATE OF BIRTH	LANGUAGES SPOKEN
SPECIALTY/PRACTICE		

PRACTICE/OFFICE INFORMATION

Enter the information of the clinic where the above provider will be added

BASIC INFORMATION

PRACTICE NAME		CONTACT PERSON	CONTACT PHONE NUMBER
NUMBER OF PRACTICES (if attaching provider to more than one location, fill out the additional clinic information and addresses on page 2)		TYPE OF PRACTICE: ❒ Sole Proprietorship ❒ Other (please explain): ❒ Partnership ❒ Corporation	
PRACTICE TELEPHONE	PRACTICE FAX NUMBER	EMAIL ADDRESS	
TAX I.D. NUMBER*		GROUP (TYPE 2) NPI NUMBER	

DATE PROVIDER BEGAN SEEING PATIENTS AT THIS CLINIC LOCATION:

ADDRESS INFORMATION

PHYSICAL ADDRESS	CITY	STATE	ZIP CODE _____ - ____
MAILING ADDRESS	CITY	STATE	ZIP CODE _____ - ____
BILLING/CHECK ADDRESS	CITY	STATE	ZIP CODE _____ - ____

*If this is a new practice (not yet enrolled with Blue Cross Blue Shield of Wyoming), please attach a copy of the practice's W-9.

BLUE CROSS BLUE SHIELD OF WYOMING
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CLINIC #2 INFORMATION				
CLINIC NAME (if different from location #1 Clinic Name)				
PRACTICE TELEPHONE	PRACTICE FAX NUMBER	GROUP (TYPE 2) NPI NUMBER		
PHYSICAL ADDRESS		CITY	STATE	ZIP CODE _____ - ____
MAILING ADDRESS		CITY	STATE	ZIP CODE _____ - ____
BILLING/CHECK ADDRESS		CITY	STATE	ZIP CODE _____ - ____

CLINIC #3 INFORMATION				
CLINIC NAME (if different from location #1 Clinic Name)				
PRACTICE TELEPHONE	PRACTICE FAX NUMBER	GROUP (TYPE 2) NPI NUMBER		
PHYSICAL ADDRESS		CITY	STATE	ZIP CODE _____ - ____
MAILING ADDRESS		CITY	STATE	ZIP CODE _____ - ____
BILLING/CHECK ADDRESS		CITY	STATE	ZIP CODE _____ - ____

CLINIC #4 INFORMATION				
CLINIC NAME (if different from location #1 Clinic Name)				
PRACTICE TELEPHONE	PRACTICE FAX NUMBER	GROUP (TYPE 2) NPI NUMBER		
PHYSICAL ADDRESS		CITY	STATE	ZIP CODE _____ - ____
MAILING ADDRESS		CITY	STATE	ZIP CODE _____ - ____
BILLING/CHECK ADDRESS		CITY	STATE	ZIP CODE _____ - ____

Please use additional copies of page 2 for more than four clinic locations.

RETURN THIS FORM TO:
EMAIL: provider.relations@bcbswy.com
FAX: 307-632-1654
MAIL: BCBSWY
Attn: Provider Relations
PO Box 2266
Cheyenne, WY 82003