# PRACTICE/OFFICE INFORMATION FORM

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| **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** |
| CLINIC NAME | CLINIC CONTACT | CLINIC PHONE:CLINIC FAX: |
| EMPLOYMENT STATUS:* Employee  Independent Contractor
* Sole Proprietor1
 | TYPE OF PRACTICE:* Sole Proprietorship  Other (please explain):
* Partnership  Corporation
 |
| NUMBER OF PRACTICES **(If attaching provider to more than one location, fill out the additional clinic information and addresses on page 2)** |
| CLINIC WEBSITE |
| TAX ID NUMBER | GROUP (TYPE 2) NPIIS THIS NEW? Y/N  | CLINIC EMAIL ADDRESS |
| CREDENTIALING CONTACT | CREDENTIALING E-MAIL ADDRESS |
| CREDENTIALING PHONE |
| **IS THIS PROVIDER ACCEPTING NEW PATIENTS?*** **Yes**  **No**
 | **DATE PROVIDER BEGAN SEEING PATIENTS AT THIS CLINIC LOCATION:** |
| **HANDICAP ACCESSIBLE:*** **Yes**  **No**
 |
| **TELEMEDICINE?*** **Yes**  **No**
 |
| **ADDRESS INFORMATION** |
| PHYSICAL ADDRESS\*Replacing Address Y/N :  | CITY | STATE | ZIP CODE- |
| MAILING ADDRESS\*Replacing Address Y/N:  | CITY | STATE | ZIP CODE- |
| BILLING/CHECK ADDRESS\*Replacing Address Y/N:  | CITY | STATE | ZIP CODE- |

1Evidence of Individual Liability Insurance is required

2If this is a new practice (not yet enrolled with Blue Cross Blue Shield of Wyoming), please attach a copy of the clinic's W-9.

# BLUE CROSS BLUE SHIELD OF WYOMING PRACTICE/OFFICE INFORMATION FORM

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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- |
| **HANDICAP ACCESSIBLE:****Yes**  **No** | **TELEMEDICINE?****Yes**  **No** |

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| **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- |
| **HANDICAP ACCESSIBLE:****Yes**  **No** | **TELEMEDICINE?****Yes**  **No** |

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| **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- |
| **HANDICAP ACCESSIBLE:****Yes**  **No** | **TELEMEDICINE?****Yes**  **No** |

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

**RETURN THIS FORM TO:**

**EMAIL:** provider.relations@bcbswy.com