# 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) NPI  IS 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** | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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](mailto:provider.relations@bcbswy.com)