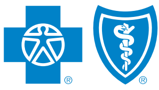

BlueCross BlueShield of Texas

Check Your Data

How to use our Demographic Change Form to verify directory information

Federal law requires that certain **directory information be verified every 90 days**, and that we remove you from our provider directory, **Provider Finder®**, if it isn't.

Professional Providers

Professional providers **have two options to verify their data** every 90 days:

- **Availity®** Provider Data Management feature, which we recommend as a quick way to verify information with us and other insurers, or
- Our online **Demographic Change Form**, which can be found on the **Verify and Update Your Information page** on our Provider website.

Follow the steps in this guide to verify your data using the Demographic Change Form. **Groups with multiple providers** must submit the form for each provider in the group per location. Use the Google Chrome browser for best results.

If you need to change your data:

- You **may continue to use the Demographic Change Form** to update your data. When updating, complete all relevant and required fields on the form. See the **Demographic Change Form User Guide**.
- Some data can be updated through the Availity Provider Data Management feature.

If you update your information, **it will count as your 90-day verification**.

Facilities and Ancillary Providers

The **Demographic Change Form** is the only way for facilities and ancillary providers to verify and update data.

We won't accept demographic changes by email, phone or fax to enable us to meet the two-day directory update requirement defined by federal law.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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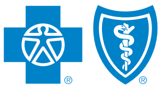


BlueCross BlueShield of Texas

Instructions for Professional Providers, Facilities and Ancillary Providers

To verify information using the Demographic Change Form

1. Fill in **required fields** on the first page to start the verification process.

Select **Individual Provider**, **Group/Clinic** or **Facility/Ancillary**, as appropriate and enter required information.

- If submitting for an Individual Provider, select **Type 1 NPI**.
- If submitting for Group/Clinic or Facility/Ancillary, select **Type 2 NPI**.

Select **Next** when complete.

Change Existing Demographic Information

Identification Information

** Indicates required field*

* Type of Provider ○ Individual Provider ○ Locum Tenens ○ Group/Clinic ○ Facility/Ancillary

Submitter Information	Provider Information
* First Name:	* Name of Provider/Group:
* Last Name:	* Tax ID Number:
* Telephone Number: *Numeric digits only* Ext: *Numeric digits only*	Rendering NPI:
* Job Title/Position:	* Billing NPI Number:
* Email Address: *you@example.com*	* Type ○ Type 1 (Individual) ○ Type 2 (Group)

Next

2. Select **Name, Office Physical Address** and **Other Provider Updates** to see the information that must be verified.

If you are verifying multiple locations:

- You must submit the form for each location.
- Select **Name, Office Physical Address** and **Other Provider Updates** for your first submission.
- For your next submissions, you won't need to select **Name** or **Other Provider Updates**.

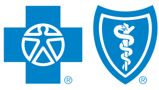
When complete, select **Next**.

Change Existing Demographic Information

Type of Change

- [x] Name
- [ ] NPI/Tax
- [x] Office Physical Address
- [ ] Billing Address
- [ ] Credentialing Address
- [ ] Administrative Address
- [x] Other Provider Updates

Back Next



BlueCross BlueShield of Texas

3. Verify name.

Individual Providers: Fill in the **Name** fields.

Group/Clinic or Facility/Ancillary: Fill in **Current Practice Name**.

For **Effective Date of Change**:

- When **verifying data**, fill in **today's date**.
- When **changing data**, fill in **date of change**.

Select **Next** when complete.

Change Existing Demographic Information

Name Change

** Indicates required field*

Attach signed and dated W-9 for name change. If you have multiple titles please list additional titles in the below comments box.

Current Name	**New Name**
First Name: Individual Provider	First Name:
Middle Name	Middle Name:
Last Name:	Last Name:
Suffix:	Suffix:
Current Title:	New Title:
Current Practice Name: Group/Clinic/Facility/Ancillary	New Practice Name:

Additional Information

Comments:

* Effective Date of Change:

Attach Documentation:

Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.

Combined file size = 0.0 MB

Choose File No file chosen

+ Add another file

Back

Next

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4. Verify office physical address.

Fill in the office **Address**, **City**, **State**, **ZIP code**, **Telephone Number** and **Email**.

Fill in today's date for **Effective Date of Change** if you're verifying information.

Select **Next** when complete.

Change Existing Demographic Information

Office Physical Address/Telephone/Fax/Email/Hours of Operation Change

** Indicates required field*

Complete a separate form for each office physical address change request. This information is utilized for the member directories. A P.O. Box address will not be accepted as an official physical address. If your primary address change involves moving to a different county, this could impact your claims payment.

Current Office Physical Address

Address Line 1:

Address Line 2:

City:

State: Zip Code:

Telephone Number: *Numeric digits only.* Ext: *Numeric digits only.*

Email: *you@example.com*

Fax Number: *Numeric digits only. For example: 1234567890*

New Office Physical Address

Address Line 1:

Address Line 2:

City:

State: Zip Code:

Telephone Number: *Numeric digits only.* Ext: *Numeric digits only.*

Email: *you@example.com*

Fax Number: *Numeric digits only. For example: 1234567890*

Additional Information

Comments:

* Effective Date of Change:

Attach Documentation:

Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.

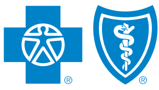
Combined file size = 0.0 MB

Choose File No file chosen

\+ Add another file

Back

Next

 BlueCross BlueShield of Texas

5. Verify specialty and submit form.

Under **Other Provider Updates**, fill in **Specialty**. It is the only data in this section that must be verified.

If verifying information, fill in today's date for **Effective Date of Change**.

When complete, select **Submit Form**.

You will receive a case number confirming you've verified or changed your data after you submit the form.

Change Existing Demographic Information

Other Provider Updates

** Indicates required field*

Current Information

Hospital Privilege (list all):

Ambulatory Surgery Center Privileges (list all):

License Number:

Specialty:

Subspecialty:

Specialty Effective Date:

Specialty Certification Date:

Board Certified: ○ Yes ○ No

Provide Lactation Services: ○ Yes ○ No

Medication Assisted Treatment

Are you a physician authorized to dispense Medication-Assisted Treatment (MAT) for Opioid Use Disorders?

○ Yes ○ No

Is Medication Assisted Treatment for Opioid Use Disorders provided at this location?

○ Yes ○ No

New Information

Hospital Privilege (list all):

Ambulatory Surgery Center Privileges (list all):

License Number:

Specialty:

Subspecialty:

Specialty Effective Date:

Specialty Certification Date:

Board Certified: ○ Yes ○ No

Provide Lactation Services: ○ Yes ○ No

Date Of Birth:

DEA Number:

DEA Number Expiration Date:

Languages (spoken or written):

Additional Information

Comments:

* Effective Date of Change:

Attach Documentation:

Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.

Combined file size = 0.0 MB

Choose File No file chosen

+ Add another file

* ☐ Provider/ Group has reviewed the information listed on the BCBSTX provider finder for accuracy and is hereby attesting that all other information is accurate.

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Submit Form

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