



**BlueCross BlueShield
of Oklahoma**

June 30, 2006

Name
Address
City/State/ZIP

Dear Provider:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule adopting the National Provider Identifier (NPI) as this identifier. All HIPAA covered healthcare providers, whether individuals or organizations, must obtain an NPI for use on all HIPAA electronic transactions. These transactions include claims, eligibility/claim status inquiries and responses, referrals and remittance advices. NPIs are generated using the National Plan and Provider Enumeration System (NPPES). Once enumerated, your NPI, which is a unique ten-digit numeric identifier, will not change, and will remain with you even if you move, change specialties or practices.

The compliance date for covered entities to obtain and use an NPI in HIPAA covered transactions is May 23, 2007. Upon the implementation of NPI, it will be the sole provider identifier, and will replace the multiple provider identification numbers you currently use today. Use of Medicare UPINs, Blue Cross and Blue Shield Provider Numbers, CHAMPUS Number, Medicaid IDs, etc. will no longer be permitted as of May 23, 2007.

If you already have an NPI, please complete the enclosed NPI Submission Form and return it to us, along with a copy of your confirmation letter from NPPES. You may mail or fax the forms to:

**Health Industry Relations
Blue Cross Blue Shield of Oklahoma
P.O. Box 3283
Tulsa, OK 74102-9969
Fax #: 866-900-2634**

If you have not already done so, you can apply for your NPI in one of the following ways:

1. **Online Application:** The Web address is <http://www.cms.hhs.gov>.
2. **Mail:** You may prepare a paper application and send it to:

**NPI Enumerator
P. O. Box 6059
Fargo, ND 58108-6059**

A copy of the application is available on <https://nppes.cms.hhs.gov>. If you need the application form sent to you, or have questions regarding the application process, please call the enumerator at **1-800-465-3203**.

We anticipate by the fall of 2006, HCSC will begin accepting NPI numbers in conjunction with your existing BCBS ID on standard electronic claim transactions, establishing a sufficient transition period before the May 23, 2007 compliance date. In the meantime, you **should not** begin using your NPI number on transactions until we have communicated a specific effective date and issued instructions on its use.

Over the next few months we will share more specific information about when, where, and how we plan to receive and communicate NPI in all covered standard electronic transactions. The Centers for Medicare and Medicaid Services (CMS) has an NPI Resource online at <http://www.cms.hhs.gov/NationalProvStand/>. You can also check for updates on the BCBSOK Web site at <http://www.bcbsok.com> or in our *Network News* provider newsletter.

Sincerely,

Blue Cross and Blue Shield of Oklahoma

Individual National Provider Identifier (NPI) Submission Form Instructions

The attached form is intended as a tool to assist with recording and validating NPI information. It is broken into six sections.

Section 1 Provider General Information

This section reflects current information about the provider. Name, tax identification number, and current BCBSOK provider number(s). This information needs to be validated and any missing information added. This section must be completed in full.

Section 2 NPI Information

Record your 10-digit National Provider Identifier here. It should be taken directly from the confirmation letter received from the enumerator. **Please note:** A copy of the enumerator letter or e-mail must be submitted with this form. Failure to submit a copy will cause delays in loading your NPI information in our systems, which could potentially have an adverse impact on the payment of claims after the HIPAA mandated NPI implementation date.

Sections 3 Primary Office Address

A primary office address must be designated. This is the primary practice or physical location where the provider performs most services. If a separate mailing address is used, it should be included in this section.

Section 4 Additional Location

Up to three additional locations may be included on the form. If more than three locations need to be reported additional forms may be completed and attached. If a separate mailing address is used for the additional location, it should also be included.

Section 5 Contact Information

Contact information contains the name of the individual completing this form. This will provide for a single point of contact to resolve any questions related to the information submitted. Please include contact name, contact phone number, contact fax number, and contact e-mail address.

Section 6 Return Information

Please mail or fax your completed form and a **copy of the enumerator's letter or confirmation e-mail** as soon as possible to the location indicated.



BlueCross BlueShield of Oklahoma

Individual National Provider Identifier (NPI) Submission Form

Please print:

Section 1 - Provider General Information

Physician's/Provider's Last Name, First Name, MI, Degree/Title
TIN#: Existing BCBSOK Provider #(s):

Section 2 - NPI Information

National Provider Identifier (NPI)#:

NOTE: YOU MUST SUBMIT A COPY OF THE LETTER OR E-MAIL FROM THE ENUMERATOR VERIFYING NPI ASSIGNMENT

Sections 3 - Primary Office Address

Physical Address Information

Address 1: City:

State: Zip Code: Phone Number: Fax No:

Provider E-mail Address:

Mailing Address Information - if different

Street: City:

State: Zip Code: Phone Number: Fax No:

Provider E-mail Address:

Section 4 - Additional Location #1

Physical Address Information

Address 1: City:

State: Zip Code: Phone Number: Fax No:

Provider E-mail Address:

Mailing Address Information - if different

Street: City:

State: Zip Code: Phone Number: Fax No:

Provider E-mail Address:

Section 4 - Additional Location #2

Physical Address Information

Street: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____ Fax No: _____

Provider E-mail Address: _____

Mailing Address Information – if different

Street: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____ Fax No: _____

Provider E-mail Address: _____

Section 4 - Additional Location #3

Physical Address Information

Street: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____ Fax No: _____

Provider E-mail Address: _____

Mailing Address Information – if different

Street: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____ Fax No: _____

Provider E-mail Address: _____

Section 5 - Contact Information

Name of Individual Completing Form: _____

Phone no: _____ Fax no: _____ Contact Email Address: _____

Additional locations may be submitted using additional forms

Section 6 - Return Information:

Please mail or fax your completed form and supporting documentation to:

**Health Industry Relations
Blue Cross Blue Shield of Oklahoma
P.O. Box 3283
Tulsa, OK 74102-9969**

Fax #: 866-900-2634

FOR OFFICE USE ONLY: