PROVIDER NOTIFICATION FORM

PROVIDER NAME	Title	Rendering/Individual NPI#:

☐ Add info/location ☐ Change info/location ☐ Close location

PLACE YOUR ADD/CHANGE IN THIS COLUMN **EFFECTIVE DATE** →	**EFFECTIVE DATE** ***(Changes take effect at 12:01am of this date)*** _____/_____/______ **MM DD YYYY**	**PLACE ANY CLOSED OFFICES IN THIS COLUMN** ***(For a list of your locations in our database, please refer to Provider Finder at www.bcbsok.com, if necessary)***	**EFFECTIVE DATE** ***(Changes take effect at 12:01am of this date)*** _____/_____/______ **MM DD YYYY**
State License Number **(attach copy of license):**		State License Number:	
Hospital Privileges at (if applicable)		Hospital Privileges at (if applicable)	
Supervising Physician: (if NP or PA)		Supervising Physician: (if NP or PA)	
Primary Specialty:		Primary Specialty:	
Board Certified? □YES □ NO	If "NO", Date of Graduation/Residency Completion: _________	Board Certified? □YES □ NO	If "NO", Date of Graduation/Residency Completion: _________
Physical Address:		Physical Address:	
Physical City, State, Zip:		Physical City, State, Zip:	
Pay To Address:		Pay To Address:	
Pay To City, State, Zip:		Pay To City, State, Zip:	
Appointment Telephone Line:	Fax Telephone:	Appointment Telephone Line:	Fax Telephone:
Group Name (if applicable):		Group Name (if applicable):	
Where do you render services for this location? (i.e. office, surgery center and/or hospital)		Where do you render services for this location? (i.e. office, surgery center and/or hospital)	
Tax ID# **(attach copy of W9)**:		Tax ID# (attach copy of W9):	
Group/Organizational NPI (if applicable):		Group/Organizational NPI (if applicable):	
Contact Person in Office:	Contact's Telephone#	Contact Person in Office:	Contact's Telephone#
Contact Persons Email Address:		Contact Persons Email Address:	
Office Hours: Mon ______ to_______ Tue_______ to_______ Wed ______ to_______ Thu ________to________ Fri ________ to______ Sat ________to________ Sun _______to________		Office Hours: Mon ______ to_______ Tue_______ to_______ Wed ______ to_______ Thu ________to________ Fri ________ to________ Sat ________to________ Sun _______to________	

****COMPLETION OF THIS FORM DOES NOT MEAN THAT YOU ARE A CONTRACTED PROVIDER****

Please provide the following information for the location listed in the left hand column above, so that we may contact you via email for the limited reasons specified below.

- The email information will be used for providers who are interested in becoming a participating provider and providers who are participating currently.
- Please add bcbsok.com and HCSC.net to your email settings to receive email from us in your inbox, or email may be sent to your SPAM or JUNK folder

1. Communication Information: Provider Newsletters and Notifications will be sent to this email
   a. Contact Name: ___________________________
   b. Email Address: _____________________________
2. Credentialing Information: This email will be used for contacting the provider regarding credentialing matters.
   a. Contact Name: ________________________________
   b. Contact Phone: _______________________________
   c. Email Address: ________________________________
   d. Mailing Address: ____
3. Network/Contracting Information: This email will be used for network/contracting information.
   a. Contact Name: ________________________________
   b. Email Address: __________________________________

THE FOLLOWING FIELDS ARE OPTIONAL – BCBSOK IS REQUESTING THIS INFORMATION IN ORDER TO MATCH YOUR INFORMATION ACCURATELY AND EFFICIENTLY WITH CAQH – THIS INFORMATION WILL ONLY BE USED FOR CREDENTIALING PURPOSES

SSN#: ____________________________ D.O.B: _____________________________

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☐ I have attached the required documentation as noted above.

Authorized Signature:____Date:__________________

Return to: BlueCross and BlueShield of Oklahoma
ATTN: Provider Services
1400 S. Boston Ave.
Tulsa, OK 74119
FAX: 918-551-3413

☐ Check here if you are interested in receiving information about becoming a participating provider.