



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[®] Essentials](#)  Provider Data Management ([PDM](#)) [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.
- Some data can be updated through the Availity [PDM 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.



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

* First Name:

* Last Name:

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

* Job Title/Position:

* Email Address:
you@example.com

Provider Information

* Name of Provider/Group:

* Tax ID Number:

Rendering NPI:

* Billing NPI Number:

* 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

☒ Name
☐ NPI/Tax
☒ Office Physical Address
☐ Billing Address
☐ Credentialing Address
☐ Administrative Address
☒ Other Provider Updates

Back

Next



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



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: Ext:

Numeric digits only. 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: Ext:

Numeric digits only. 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

No file chosen

Add another file



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	New Information
Hospital Privilege (list all): <hr/>	Hospital Privilege (list all): <hr/>
Ambulatory Surgery Center Privileges (list all): <hr/>	Ambulatory Surgery Center Privileges (list all): <hr/>
License Number: <hr/>	License Number: <hr/>
Specialty: <hr/>	Specialty: <hr/>
Subspecialty: <hr/>	Subspecialty: <hr/>
Specialty Effective Date:	Specialty Effective Date:
Specialty Certification Date:	Specialty Certification Date:
Board Certified: <input type="radio"/> Yes <input type="radio"/> No	Board Certified: <input type="radio"/> Yes <input type="radio"/> No
Provide Lactation Services: <input type="radio"/> Yes <input type="radio"/> No	Provide Lactation Services: <input type="radio"/> Yes <input type="radio"/> No
<h4>Medication Assisted Treatment</h4> <p>Is Medication Assisted Treatment for Opioid Use Disorders provided at this location?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	Date Of Birth: Languages (spoken or written): <hr/>
<h4>Additional Information</h4> <p>Comments: <div></div></p>	<div><p>* Effective Date of Change: </p><p>Attach Documentation: <small>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.</small></p><p>Combined file size = 0.0 MB <input type="button" value="Choose File"/> No file chosen <input type="button" value="+ Add another file"/></p></div>

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

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