BlueCross BlueShield of Montana

CHANGE OF STATUS FORM

The following information is intended to replace information currently on file. Mark the applicable boxes and complete the corresponding information. If a provider is leaving a practice, complete the "Delete a Provider from Your Office" information. New contracts will be required for a provider's new practice and can be obtained by calling 1-800-447-7828, Extension 6100 or send email to MT_HCSSPEC@hcsc.net.

Update/Change (please check all that apply)

☐ Add Additional Location ☐ Change Physical Address ☐ Add/Change Payment Address

☐ Update Tax I.D. ☐ Other Changes ☐ Delete a Provider from Your Office

Current Information (required)

Provider Name____ Tax ID ________________________

Office Name ____ Phone ______________________________

Physical Address _________________________________City _______________ State ____ Zip _______

Contact Name __________________________________Phone if different from above ___________________

Add an Additional Practice Location

Provider Name ____ Tax ID ______________________

Office Name ____ Phone ____________ Fax _____________

Physical Address _________________________________City ______________ State ____ Zip __________

Effective Date ________________ Is the Payment Address the Same? ☐ Yes ☐ No (if not please provide)

Payment Address________________________________ City______________ State ____ Zip __________

Physical Address Change

Provider Name ____ Tax ID _____________________

Office Name ____ Phone ___________ Fax ____________

New Physical Address___________________________________ City ____________ State ___ Zip ________

New Mailing Address ___________________________________ City ______________ State ___ Zip ________

Effective Date ______________ Contact Name ____

Is the Payment Address the Same? ☐ Yes ☐ No (if not please provide below)

Payment Address _________________________________City _______________ State ____ Zip________

Change of Payment Address

New Payment Address ___________________________________ City ______________ State ____ Zip_________

Effective Date ________________

Phone ___________________ Fax _______________ Name of Contact Person ______________________________

Change of TAX ID or SSN

Current Tax ID _____________________

New Tax ID/SSN ______________________ Effective Date ________________

Can your New Tax ID be used for the entire current tax year? ☐ Yes ☐ No

Other Changes

Accepting New Patients? ☐ Yes ☐ No

Email Address _______________________________________ Office Hours _______________________________

Name Change _______________________________________

Delete a Provider from Your Office

Provider Name _______________________________________ *Effective Date _____________

Reason for Deletion (i.e., retired, relocated) ____

New Location Information if Available: New contracts are required for a new practice and can be obtained by calling a Provider Service Representative at 1-800-447-7828, Extension 6100 or send email to HCSX6100@bcbsmt.com.

Address ____ City __________________ State ____ Zip ________

Phone __________________ Fax ____________________

*The provider's current contracts will be terminated on the effective date listed.

Print Name ____ Phone Number ____________________________

Signature ____ Date ______________

Mail or Fax to:

Blue Cross and Blue Shield of Montana

Health Care Services

P. O. Box 4309, Helena, MT 59604

Fax: 406-437-7879