BlueCross BlueShield of Oklahoma

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

First Name:
Individual Provider

Middle Name

Last Name:

Suffix:

Current Title:

Current Practice Name:
Group/Clinic/Facility/Ancillary

New Name

First Name:

Middle Name:

Last Name:

Suffix:

New Title:

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	**New Office Physical Address**
Address Line 1:	Address Line 1:
Address Line 2:	Address Line 2:
City:	City:
State: Zip Code:	State: Zip Code:
Telephone Number: Ext: (Numeric digits only.) (Numeric digits only.)	Telephone Number: Ext: (Numeric digits only.) (Numeric digits only.)
Email: you@example.com	Email: you@example.com
Fax Number: Numeric digits only. For example: 1234567890	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

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):	Hospital Privilege (list all):
Ambulatory Surgery Center Privileges (list all):	Ambulatory Surgery Center Privileges (list all):
License Number:	License Number:
Specialty:	Specialty:
Subspecialty:	Subspecialty:
Specialty Effective Date:	Specialty Effective Date:
Specialty Certification Date:	Specialty Certification Date:
Board Certified: ○ Yes ○ No	Board Certified: ○ Yes ○ No
Provide Lactation Services: ○ Yes ○ No	Provide Lactation Services: ○ Yes ○ No

Medication Assisted Treatment

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

○ Yes ○ No

Date Of Birth: _____

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 BCBSIL provider finder for accuracy and is hereby attesting that all other information is accurate.

[Back] [Submit Form]