Provider change of data

Effective date of change: _____

Please use this form to indicate changes in your data. Complete applicable sections only.

First name	**Middle initial**	**Last name**

NPI (attach copy of NPI verification of NPPES)	**Doing business as**

Date of birth	**Degree**	**Gender** ☐ Male ☐ Female	**US citizen?** ☐ Yes ☐ No	**Social Security number**

Specialty	**Secondary specialty**

Primary language/Secondary languages	**Do you provide TTY services?** ☐ Yes ☐ No	**Do you or your staff provide sign language?**

History of all active and historical licensure required- see page 2

AR License/Certification number (attach copy of license)	**State**	**Issue date**	**Expiration date**
Other License/Certification number (attach copy of license)	**State**	**Issue date**	**Expiration date**
DEA number (DEA Diversion Control Division certificate)	**State**	**Issue date**	**Expiration date**

Email address of clinic/group	**Medical records fax number**	**Medical records email**

Primary contact person	**Title**

Do you provide telehealth services? ☐ Yes ☐ No

☐ Yes ☐ No Have you ever been on the List of Excluded Individuals/ Entities (LEIE) maintained by the Office of Inspector General (OIG)? (If yes, please submit written explanation)

☐ Yes ☐ No If you have DEA issued in Arkansas you are enrolled with the Arkansas Prescription Monitoring Program ("AR PMP")?

☐ Yes ☐ No If you authorize the Arkansas Department of Health to release confirmation of your AR PMP enrollment?

(**Please note:** Network credentialing standards require enrollment in the AR PMP for those providers who hold an active DEA issued in AR. Not authorizing confirmation of your enrollment will result in rejection of your network applications)

Physical location address (Must have a street address – PO Boxes are not acceptable)	**City**	**State**	**ZIP**

Phone to be used for patient appointments	**Fax**

Office hours at this location ☐ Full time ☐ Part time

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Open							
Close							

Correspondence address (For notifications, newsletters, credentialing updates, etc.)	**City**	**State**	**ZIP**

Correspondence phone	**Correspondence fax**

PAYMENT INFORMATION - If payment to a clinic or group is required, please complete the *Authorization for Clinic Billing* form.

Are you incorporated? ☐ Yes ☐ No	**Payment EIN** (attach IRS verification of EIN)	**Payment name**

Payment address	**City**	**State**	**ZIP**

Payment phone	**Payment fax**

PATIENT RESTRICTIONS - Do you have any patient restrictions?
Please explain below. (Example: Not accepting Commercial or Blue Medicare, Age Restrictions etc.)

History of all active and historical licensure required - If additional licensure history needs to be disclosed, please attach full summary

License/Certification number	**State**	**Issue date**	**Expiration date**

Additional location name

Address	**City**	**State**	**ZIP**

Phone	**Fax**

Office hours at this location ☐ Full time ☐ Part time

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Open							
Close							

Additional location name

Address	**City**	**State**	**ZIP**

Phone	**Fax**

Office hours at this location ☐ Full time ☐ Part time

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Open							
Close							

(if additional locations need to be added, please submit an additional form or document with the locations listed as above)

Print name of individual practitioner

Signature of individual practitioner	**Date of signature**

Please email completed form with supporting documents to
providernetwork@arkbluecross.com or fax to **501-378-2465**.