Change of Information Form

Provider Information		
Provider or Facility/Clinic Name		
NPI (include both new and old NPIs if there is a change)	Tax ID (include both new and old Tax IDs if there is a change)	
Address		
City	State	Zip

Requestor Contact Information	
Requestor Contact Name	Phone
Fax	Email

Update Information

Information to be updated:

- ☐ 1099 Address
- ☐ Clinic/Practicing Address
- ☐ Mailing Address
- ☐ Check Address
- ☐ Clinic/Practice Name
- ☐ Tax ID
- ☐ Provider Name Change *(Ex. Marriage)*
- ☐ Appointment Phone Number
- ☐ Accepting New Patients

Please detail the information to be updated in the space provided below.

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SUBMIT INSTRUCTIONS

If you are having difficulty submitting the form once completed, please send using one of the following methods:

- Email (Please follow these steps):
  - Click on 'File' at the top of your screen
  - Click on 'Save As'
  - Save the completed form on your computer
  - Attach the completed form to an email and send to providerforms@bcbsnd.com
- Fax: 701-282-1910
- Mail: 4510 13th Ave S
  Fargo, ND 58121

SUBMIT FORM

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