New Location / Business Relationship

ND

Provider's Personal Data

First	MI	Last	Credentials

Social Security Number	NPI	Specialty(s)

Organization NPI	Business/Corporation Name

Malpractice Liability Insurance

Current Carrier	Policy Number

Amount of Coverage

Occurance	Aggregate

Issue Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)

New Locations

Practicing Address:

Street	City	State	Zip

Mailing/Billing Address *(If different than Practicing Address)*:

Street or PO Box Number	City	State	Zip

Tax Identification Number (TIN)	Patient Appointment Phone Number	Clinic Pre-Auth/Referral Fax Number

Provider Phone Number (if different than clinic)	Is this a Primary Practice Location for this Provider? ☐ Yes ☐ No	Display in Directory? ☐ Yes ☐ No	Effective Date (MM/DD/YYYY)

Practicing Address:

Street	City	State	Zip

Mailing/Billing Address *(If different than Practicing Address)*:

Street or PO Box Number	City	State	Zip

Tax Identification Number (TIN)	Patient Appointment Phone Number	Clinic Pre-Auth/Referral Fax Number

Provider Phone Number (if different than clinic)	Is this a Primary Practice Location for this Provider? ☐ Yes ☐ No	Display in Directory? ☐ Yes ☐ No	Effective Date (MM/DD/YYYY)

Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross & Blue Shield Association

Noridian Mutual Insurance Company

Practicing Address:			
Street	City	State	Zip

Mailing/Billing Address *(If different than Practicing Address)*:			
Street or PO Box Number	City	State	Zip

Tax Identification Number (TIN)	Patient Appointment Phone Number	Clinic Pre-Auth/Referral Fax Number

Provider Phone Number (if different than clinic)	Is this a Primary Practice Location for this Provider? ☐ Yes ☐ No	Display in Directory? ☐ Yes ☐ No	Effective Date (MM/DD/YYYY)

Practicing Address:			
Street	City	State	Zip

Mailing/Billing Address *(If different than Practicing Address)*:			
Street or PO Box Number	City	State	Zip

Tax Identification Number (TIN)	Patient Appointment Phone Number	Clinic Pre-Auth/Referral Fax Number

Provider Phone Number (if different than clinic)	Is this a Primary Practice Location for this Provider? ☐ Yes ☐ No	Display in Directory? ☐ Yes ☐ No	Effective Date (MM/DD/YYYY)

Certification/Attestation

I,____(print name) hereby certify and attest to the fact that all the information submitted by me in this form is true and accurate to the best of my knowledge and belief. Affixing my electronic signature has the same legal effect and enforceablility as my handwritten signature.

Provider's Signature

Date (MM/DD/YYYY)

Credentialing Contact Personal Information

First Name	Last Name
Email Address	

Submit

If you would like to send by email, please click submit to send electronically.

Print

If you wish to send via fax or mail, please print and

Fax to: (701) 282-1910 or

Mail to: BCBSND
Attn: Provider Networks
4510 13th Ave. S, Fargo, ND 58121

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