

Change Request Form

I. Instructions	
This form should be typed or legibly printed in black ink.	
<ul style="list-style-type: none"> ◆ If address is changing, please include the Proof of Insurance facesheet for the new location. ◆ If the tax is changing, please include the W-9 tax form. 	
Send the Completed Form w/ attachments to: Regence BlueShield Provider Network Management PO Box 21267 M/S 916 Seattle, WA 98111-3267	Or fax the Completed Form w/ Attachments to: Regence BlueShield Provider Network Management (888) 289-1313
If you have any questions, contact Regence BlueShield Provider Services at 1-800-562-2156.	

II. Old Information		
Office Street Address:	City/State/Zip	Phone Number: ()
Billing Address (if different from above):	City/State/Zip	Billing Phone Number: ()
Tax Identification Number:		

III. New Information or Additional Location (please circle)			
Name of practice / Affiliation or Clinic Name:			
NPI: <i>If you are a Type 2 provider as defined by CMS, please contact your provider relations representative to report your NPI to Regence.</i>			
Office Street Address:	Suite:	City/State/Zip	Phone Number: () Fax Number: ()
<input type="checkbox"/> Check if this is a home address			
Billing Address (if different from above):		City/State/Zip	Billing Phone Number: ()
Tax Identification Number (if changing):			
Owner of Tax:			
Effective Date:	Contact Name and Phone Number: ()		
Providers Affected by This Change:			

Requestor Signature: _____