Provider File Maintenance Request

Please note that this form may be used for providers of Highmark Inc. ("Highmark") and certain of its affiliates: Highmark West Virginia Inc. ("Highmark WV"), Highmark Health Insurance Company ("HHIC") and Highmark BCBSD Inc. ("Highmark DE"). Highmark, Highmark WVA, HHIC and Highmark DE may each be referred to herein as the "Plan". When the term "Plan" is used, it will mean each Plan that the Provider contracts with as a network provider. This form covers specific products of the Plan, as offered in a Plan's service area and for which the Provider is credentialed.

Starting on January 1, 2019, this Fillable PDF Form will be discontinued in favor of our Electronic Forms, which are processed faster than Fillable PDF Forms. The Electronic Forms can be found on the Provider Resource Center in your region under "Forms", "Provider Information Management Forms".

Group Information

Name of Account (DBA name) _____

Tax ID _____ Tax ID Name _____

Type 2 (Group) National Provider Identifier _____ Highmark Group Number _____

Complete for Address Changes *(**Note**: For NaviNet users, changes should be made online.)*

☐ Change **Main Practice** address ☐ Change **Practice** address(es) ☐ Change **Credentialing Contact** (see page 2)

☐ Change **Check** address ☐ Change **Mailing** address

Effective date of addition/change

Main Practice Address (primary physical practice location) *(PO Box numbers are **NOT** acceptable)*

Group PROMISE ID at this location _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip+4 _____

Member Access Number: _____ Patients call this number to make an appointment for this location.

Telephone number: _____

Fax number: _____

Practitioner names/PROMISE IDs at this location* — Practitioner PROMISE ID

① _____ _____

② _____ _____

③ _____ _____

④ _____ _____

Accepting new patients? ☐ Yes ☐ No

Office hours	*Monday*	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*	*Sunday*

Additional Practice Address 1 Group PROMISE ID _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip+4 _____

Telephone number: _____

Fax number: _____

Practitioner names/PROMISE IDs at this location* — Practitioner PROMISE ID

① _____ _____

② _____ _____

③ _____ _____

④ _____ _____

Accepting new patients? ☐ Yes ☐ No

Office hours	*Monday*	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*	*Sunday*

Additional Practice Address 2* Group PROMISE ID _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip+4 _____

Telephone number: _____

Fax number: _____

Practitioner names/PROMISE IDs at this location* — Practitioner PROMISE ID

① _____ _____

② _____ _____

③ _____ _____

④ _____ _____

Accepting new patients? ☐ Yes ☐ No

Office hours	*Monday*	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*	*Sunday*

** Use a separate sheet for additional practice addresses and / or practitioners at each location.*

Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association

Mailing Address (if different than Main Practice and Check Address)

Address 1 _____

Address 2 _____

City _____ State ____ Zip+4 _____

Telephone number: _____

Fax number: _____

Check Address (where checks are sent) Is this a lockbox? ◯ Yes ◯ No

Address 1 _____

Address 2 _____

City _____ State ____ Zip+4 _____

Telephone number: _____

Fax number: _____

Credentialing Contact (contact for credentialing-related information)

Name _____ Email _____

Address 1 _____ Address 2 _____

City _____ State _____ Zip+4 _____

Telephone number: _____ Fax number: _____

Complete for Group Name / DBA Name / Tax ID Changes/ NPI Changes

Group Name Change

New Group Name: _____

Effective Date: _____

DBA Name Change

Existing DBA name: _____

New DBA name: _____

Effective Date: _____

Tax ID Change *

Existing Tax ID: _____

New Tax ID: _____

Effective Date: _____

NPI Change

Existing NPI: _____

New NPI: _____

** Note: For Tax ID changes, please complete and include the "Acknowledgement of Assignment" form found on the Provider Resource Center.*

Patient Age Ranges

Does your practice limit the age of patients you treat? ◯ Yes ◯ No

If **YES,** what ages do you treat? _____ Minimum _____ Maximum

Authorized Representative Sign Below

_____ _____

Signature of Authorized Representative of Group Date

_____ _____

Title Telephone Number

Fax the completed form to
Provider Information Management at:
(800) 236-8641