Provider Change Request Form

If your request is to change the office information only, please refer to the **Dental Office change form.**
The Provider Change Request form is to be used for all changes related to a provider, please complete **Section 1:** Office Information and **Section II:** Provider Information.

Form must be signed and dated in order to be considered complete, if any information is missing, we will contact your office for additional information. *Submit a signed/dated W9 where the (*) indicates. ** Submit your board certification / eligibility if you are a specialist

SECTION I OFFICE INFORMATION:

TIN: ________________________________ IRS Name: ________________________________
(Tax Identification Number used when submitting claims) *(Name as registered with the IRS)*

Office Name: ________________________________
(***Doing Business As,*** *if different than IRS name, please indicate)*

Office Address: ________________________________
(Address, bldg., ste #, City, ST, Zip) Address listed here must be used when submitting a claim

Phone: ________________________________ Fax: ________________________________
Only required if you are adding a new office)

Office Email: ________________________________

Billing Address: ________________________________
(Only required if you are adding a new office) *(Address, bldg., ste #, City, ST, Zip)*

Correspondence Address:

____
(Only required if you are adding a new office) (Address, bldg., ste #, City, ST, Zip)

Please Indicate Change(s) Below:

☐ **Add New Location** Effective Date of new Office:

____

(Office information above is required, along with provider information in section II. If you are adding more than one location and/or provider, please complete additional forms and attached a current *** W9 signed/dated.)**

SECTION II PROVIDER INFORMATION:

Last Name ________________________________ First Name: ________________________________ MI ______

License Number: ________________________________
(License # listed here must be used when submitting claims)

** Specialty: NPI: ________________________________
(Type 1 Individual NPI)

Are you an owner, partner or associate of the office location above? ☐ Owner ☐ Partner ☐ Associate

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HZN OFFICE
32431 (W1018)

Please indicate request below:

☐ **Add Provider to office Address identified in Section 1**
(If a provider is not currently participating with Horizon, call 1-800-433-6825 for assistance on what is required in order to add your provider.)

☐ **Provider Change:** ☐ Name Change ☐ License Change ☐** Specialty Change ☐ Other

New Name: ____
(First / MI / Last Name)

New License: ______________________________
(License # listed here must be used when submitting claims)

Specialty Change to:

Other (please indicate change): ______________________________________

Please indicate the network provider desires:

☐ No Change from existing location or ☐ Traditional/DOP ☐ PPO ☐ FEP ☐ 1262* ☐ HDC*
*These Networks may be subject to approval

For your convenience, we have provided you with a mail to. Please sign, date and return the form to one of the contacts below:

Mail To: Horizon Blue Cross Blue Shield of NJ Dental Programs
Attn: Dental Services Manager
3 Penn Plaza East PP-13Y
Newark, NJ 07105
Fax: (973) 274-2202

By signing this form, you are an authorized signee on behalf of the practice and attest that the information contained in this form is accurate and correct. ***Form must be signed and dated on unique lines in order to process any of the requested changes.***

Signature: ______________________ Please Print: ____________________________

Date: ____________________