



An Anthem Company

### Practice Profile Update Form

To update your practice profile, send new information using the form below to the Provider Relations department via email to [nyprovupdates@empireblue.com](mailto:nyprovupdates@empireblue.com). If you have any questions or need assistance, please contact your local Provider Relations representative or call **1-800-450-8753**.

1. Do not complete the entire form; only fill in sections where your information has changed.
2. You must complete the **Provider information** section.
3. Sign and date the form before faxing.

Provider information			
Provider name:		Specialty:	
License number:		NPI:	
Provider email:			Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
What type of information are you updating?			
<b>Please check all that apply.</b>			
<input type="checkbox"/> Practice details	<input type="checkbox"/> New or an additional office location		
<input type="checkbox"/> Primary care provider details	<input type="checkbox"/> Remove an office location		
<input type="checkbox"/> Billing information	<input type="checkbox"/> Other: _____		
Practice details			
Office hours:	From:	To:	Age range of patients served:
Monday	_____ a.m.	_____ p.m.	<input type="checkbox"/> Pediatric <input type="checkbox"/> Geriatric
Tuesday	_____ a.m.	_____ p.m.	<input type="checkbox"/> All ages <input type="checkbox"/> Other: _____
Wednesday	_____ a.m.	_____ p.m.	Languages spoken: _____
Thursday	_____ a.m.	_____ p.m.	Wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No
Friday	_____ a.m.	_____ p.m.	
Saturday	_____ a.m.	_____ p.m.	
Sunday	_____ a.m.	_____ p.m.	
Primary care provider details			
Primary care providers are <b>required</b> to have coverage 24 hours a day, 7 days a week. Please mark your coverage type below.			
<input type="checkbox"/> Answering service <input type="checkbox"/> Beeper or pager <input type="checkbox"/> Answering machine			
<input type="checkbox"/> Other phone number: _____			
Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, please explain: _____			

**Billing information**  
Please attach a copy of the current W-9 form for all billing information changes.

New tax ID number? <input type="checkbox"/> Yes <input type="checkbox"/> No	Tax ID number:	
Billing address:		
Contact person:		
City:	State:	Zip:
Phone number:	Fax number:	

**New or an additional office location**

New location    Additional location

Site name:

Site address:

City:	State:	Zip:
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Office manager:

Phone number:	Fax number:
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Office hours:	From:	To:	Age range of patients served:
Monday	_____ a.m.	_____ p.m.	<input type="checkbox"/> Pediatric <input type="checkbox"/> Geriatric
Tuesday	_____ a.m.	_____ p.m.	<input type="checkbox"/> All ages <input type="checkbox"/> Other: _____
Wednesday	_____ a.m.	_____ p.m.	
Thursday	_____ a.m.	_____ p.m.	Languages spoken: _____
Friday	_____ a.m.	_____ p.m.	
Saturday	_____ a.m.	_____ p.m.	Wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sunday	_____ a.m.	_____ p.m.	

**Remove an office location**

Site name:

Site address:

City:	State:	Zip:
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Office manager:

Phone number:	Fax number:
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**To add or remove additional office locations, attach a separate sheet.**

**Please sign and date**

Signature: \_\_\_\_\_ Printed name: \_\_\_\_\_

Contact phone number: \_\_\_\_\_ Date completed: \_\_\_\_\_

*For office use only*

Date received by Empire BlueCross BlueShield HealthPlus: \_\_\_\_\_