Individual Practitioner Information Change Form (ICF-01)

The data provided on this form or additional form with equivalent data is used by Blue Shield of California (Blue Shield) and/or Blue Shield of California Promise Health Plan (Blue Shield Promise) to add, change, or remove information on an established practitioner record. Blue Shield and/or Blue Shield Promise will confirm that the request has been processed.

Instructions

Identify the practitioner requiring changes by populating the Practitioner Name, Tax Identification Number (TIN), and National Provider Identifier (NPI) fields. Complete all applicable fields that require changes. Attach all required documentation, as outlined below, and return this form to Blue Shield and/or Blue Shield Promise via email at **BSCProviderInfo@blueshieldca.com**. This form may be completed electronically.

Required Documentation

This request will not be initiated until all the required documentation, as indicated below, is received by Blue Shield and/or Blue Shield Promise. Failure to provide the required documentation will result in no action being taken.

- For changes to your corporation or business structure: Please submit the Articles of Incorporation with this form.
- For changes to your Employer Identification Number (EIN) or Tax Identification Number (TIN): Please submit a signed W-9 or Department of Treasury/Internal Revenue Service (IRS) tax document.
- For all other changes to your information, no supporting documentation is required.

Additional Information

This form is only used to update existing practitioner records. To create a new practitioner record, please complete the Practitioner Record Application (Form RA-01). This form is not an agreement to participate in the Blue Shield or Blue Shield Promise provider network. For information about joining either network, please contact our Provider Information and Enrollment Department via email at **BSCProviderInfo@blueshieldca.com**.

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By submitting this form applicant certifies on behalf of this provider record that all information included on this form is true, accurate and complete. Any false statements, the concealment of material fact, or the use of false documents may lead to prosecution under applicable federal or state laws. Applicant certifies under penalty of perjury that the foregoing is true and correct. To **ADD** information, check the **ADD** box and use the **NEW** column. To **CHANGE** information, check the **CHANGE** box and use the **EXISTING** and **NEW** columns. To **REMOVE** information, check the **REMOVE** box and use the **EXISTING** column.

Identify the provider group record requiring change(s):

Name	
Tax identification number (TIN)	
National Provider Identifier (NPI)	

Add	Change	Remove	Information	Existing	New
☐	☐	☐	**Name**		
☐	☐	☐	**Primary specialty/type of service**		
☐	☐	☐	**Secondary specialty**		
☐	☐	☐	**Practitioner language(s)**		
☐	☐	☐	**TIN (attach pre-printed tax document /W-9)**		
☐	☐	☐	**NPI**		
☐	☐	☐	**License Number**		
☐	☐	☐	**Hospital affiliation**		
☐	☐	☐	**Service location address**		
☐	☐	☐	**Wheelchair access?**	Yes ☐ No ☐	Yes ☐ No ☐
☐	☐	☐	**Phone number**		
☐	☐	☐	**Supervising physician (if applicable)**	Name / NPI	Name / NPI
☐	☐	☐	**Practitioner ethnicity**		
☐	☐	☐	**Patient acceptance**	New and existing patients ☐ / **Gender limitations:**	New and existing patients ☐ / **Gender limitations**:
				Current patients only ☐ / N/A ☐	Current Patients only ☐ / N/A ☐
				Lowest age / Male only ☐	Lowest age / Male only ☐
				Highest age / Female only ☐	Highest age / Female only ☐

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Identify the provider group record requiring change(s):

Name	
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National Provider Identifier (NPI)	

Add	Change	Remove	Information	Existing	New
☐	☐	☐	**Telehealth (select all that apply)**	Telehealth visits ☐ In-person visits ☐	Telehealth visits ☐ In-person visits ☐
☐	☐	☐	**Hospital-based practitioner**	Yes ☐ No ☐	Yes ☐ No ☐
☐	☐	☐	**Fax number**		
☐	☐	☐	**After hours phone number**		
☐	☐	☐	**Website URL**		
☐	☐	☐	**Office hours (specify days and times)**		
☐	☐	☐	**Qualified medical interpreter**	Cantonese ☐ Spanish ☐ Vietnamese ☐ Korean ☐ Mandarin ☐ Russian ☐	Cantonese ☐ Spanish ☐ Vietnamese ☐ Korean ☐ Mandarin ☐ Russian ☐
☐	☐	☐	**Clinical staff language**		
☐	☐	☐	**Area(s) of special expertise (check all that apply)**	**Physical disability** ☐	**Physical disability** ☐
				HIV/AIDS ☐	**HIV/AIDS** ☐
				Homelessness ☐	**Homelessness** ☐
				Deafness/hard of hearing ☐	**Deafness/hard of hearing** ☐
				Blindness/visually impaired ☐	**Blindness/visually impaired** ☐
				Co-occurring disorders ☐	**Co-occurring disorders** ☐
				Chronic illness ☐	**Chronic illness** ☐
☐	☐	☐	**Billing Address**		
☐	☐	☐	**Billing phone number/Fax number**	Phone Fax	Phone Fax
☐	☐	☐	**Billing email**		