Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Mail to: Florida Blue
Network Operations
P.O. Box 41109
Jacksonville, FL 32203

Fax (904) 301-1884

Provider Information Update Form

Use this form to update your provider information (e.g., service location, payment address, tax identification number) with Florida Blue. Please complete all of Section I and only the information that is changing in Sections II–VIII. Providing complete and legible information will expedite your request and help ensure accurate processing. Mail or fax the completed form to the address and number indicated above.

Section I: Provider Information - Complete all fields below in Section I

Provider's Full Name* (last, first, middle initial/business name)		Title
Florida Blue Provider Number	Individual NPI	Organizational NPI
Medicare Number	Medical/DOH License Number	Social Security Number/Tax ID
Specialty		Effective Date of Request (MM/DD/YYYY)
Office Contact Name	Telephone Number (for appointments) ( )	Email Address

*Legal documentation (e.g., marriage license) is required for changes to last name

Note: For Sections II–VIII, complete only the section(s) that requires a change.

Section II: Languages Spoken

List non-English languages spoken by provider and/or staff in order of fluency. (If language is spoken by staff only, please check "Staff" box.)

(1) Staff ☐ (2) Staff ☐ (3) Staff ☐

Section III: Service Location

Please complete a separate form for each additional location.

■ Add new location ☐ Relocated ☐ Expire location ☐ Correction to existing location

Previous			**New** ■ Office Location ☐ Hospital Based Location ☐ Other (independent diagnostic center, supplier, etc.)		
Street Address			Street Address		
City	State	Zip	City	State	Zip
Telephone Number ( )	Fax Number ( )		Telephone Number ( )	Fax Number ( )	
Email Address			Email Address		

Section IV: Office Hours

Office Hours							
	Mon	Tue	Wed	Thu	Fri	Sat	Sun
A.M.							
P.M.							

Section V: Payment/Billing Address

A signature at the bottom of this form by the Tax ID owner is required for all payment address changes.

Previous			**New**		
Provider Name (last, first, middle initial/business name)			Provider Name (last, first, middle initial/business name)		
Street Address			Street Address		
City	State	Zip	City	State	Zip
Telephone Number ( )	Fax Number ( )		Telephone Number ( )	Fax Number ( )	
Email Address			Email Address		

Section VI: Tax Identification/Employer Identification Number (TIN/EIN)

In order to update your Tax ID, a **completed IRS Confirmation Letter** must be attached to this form.

Previous TIN/EIN	New TIN/EIN	Effective Date of Change

Section VII: Hospital Affiliation Update

A **hospital privilege letter** from the facility along with written notification from the provider's office (administrator, manager, provider, etc.) and/or **attestation form** for hospital-based physicians is required.

Hospital Name	Hospital BCBSF Provider Number	Hospital NPI	Add/Delete?	Effective/ Expiration Date
(1)			Add ☐ Delete ☐	
(2)			Add ☐ Delete ☐	

Section VIII: Professional Association Deletion

Group NPI	Effective Date of Group Disassociation	Physician NPI

Print Name of Physician/Provider _____ Signature of Physician/Provider _____

Note: A ***Billing Authorization for Professional Associations (PA) Form*** must be completed when adding a provider to a group. A ***PA Form*** **along with an attestation form** is needed for hospital-based providers.

Additional Comments

Print Name _____ Signature _____

Title _____ Date _____

For Internal Use Only: Provider Number _____