

**BLUECROSS BLUESHIELD OF OKLAHOMA  
PROVIDER NOTIFICATION**

ADD INFO / LOCATION

CHANGE INFO / LOCATION

CLOSE LOCATION

\_\_\_\_\_  
**Name (\*\* as Shown on Oklahoma License\*\*)**

\_\_\_\_\_  
**Title (\*\*as on License\*\*)**

Group Affiliation/Physical Address: \_\_\_\_\_

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

Payment Address: \_\_\_\_\_

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

State License Number: \_\_\_\_\_ Primary Specialty: \_\_\_\_\_

**\*\*Copy of State License is Required\*\***

Your National Provider Identifier: \_\_\_\_\_

Effective Date of Change: \_\_\_\_\_

Tax Identification Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**\*\*Copy of W-9 Form Required\*\***

Organization's National Provider Identification: \_\_\_\_\_

Hospital Privileges: \_\_\_\_\_

Contact person in Office: \_\_\_\_\_

Name

Phone #

E-mail Address

**Office Hours:**

**Mon** \_\_\_\_\_ **to** \_\_\_\_\_ **Tue** \_\_\_\_\_ **to** \_\_\_\_\_ **Wed** \_\_\_\_\_ **to** \_\_\_\_\_ **Thu** \_\_\_\_\_ **to** \_\_\_\_\_

**Fri** \_\_\_\_\_ **to** \_\_\_\_\_ **Sat** \_\_\_\_\_ **to** \_\_\_\_\_ **Sun** \_\_\_\_\_ **to** \_\_\_\_\_

**COMPLETION OF THIS FORM DOES NOT MEAN THAT YOU ARE A  
CONTRACTED PROVIDER**

**I HAVE ATTACHED THE REQUIRED DOCUMENTATION AS NOTED ABOVE.**

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return to: BlueCross BlueShield of Oklahoma Health Industry Relations  
1400 S. Boston  
Tulsa, OK 74119**

**FAX: ( 918 ) -551-3413**

**ATTENTION: \_\_\_\_\_ Provider Services \_\_\_\_\_**