



Check Your Data





How to use our Demographic Change Form to verify directory information

Federal law requires that certain [directory information be verified every 90 days](#), and that we remove you from our provider directory, [Provider Finder](#)[®], if it isn't.


Professional Providers

Professional providers **have two options to verify their data** every 90 days:

- [Availity[®] Essentials](#)  Provider Data Management ([PDM](#)) [feature](#), which we recommend as a quick way to verify information with us and other insurers, or
- Our online [Demographic Change Form](#) , which can be found on the [Verify and Update Your Information page](#) on our Provider website.

Follow the steps in this guide to verify your data using the Demographic Change Form. **Groups with multiple providers** must submit the form for each provider in the group per location. Use the Google Chrome browser for best results.

If you need to change your data:

- You **may continue to use the [Demographic Change Form](#)**  to update your data. When updating, complete all relevant and required fields on the form.
- Some data can be updated through the Availity [PDM feature](#).

If you update your information, **it will count as your 90-day verification**.

Facilities and Ancillary Providers

The [Demographic Change Form](#)  is the only way for facilities and ancillary providers to verify and update data.

We won't accept demographic changes by email, phone or fax to enable us to meet the two-day directory update requirement defined by federal law.



Instructions for Professional Providers, Facilities and Ancillary Providers

To verify information using the Demographic Change Form

1. Fill in **required fields** on the first page to start the verification process.

Select **Individual Provider**, **Group/Clinic** or **Facility/Ancillary**, as appropriate and enter required information.

- If submitting for an Individual Provider, select **Type 1 NPI**.
- If submitting for Group/Clinic or Facility/Ancillary, select **Type 2 NPI**.

Select **Next** when complete.

Change Existing Demographic Information

Identification Information
** Indicates required field*

* Type of Provider Individual Provider Locum Tenens Group/Clinic Facility/Ancillary

<p>Submitter Information</p> <p>* First Name: _____</p> <p>* Last Name: _____</p> <p>* Telephone Number: Ext: _____ <small>Numeric digits only Numeric digits only</small></p> <p>* Job Title/Position: _____</p> <p>* Email Address: _____ <small>you@example.com</small></p>	<p>Provider Information</p> <p>* Name of Provider/Group: _____</p> <p>* Tax ID Number: _____</p> <p>Rendering NPI: _____</p> <p>* Billing NPI Number: _____</p> <p>* Type <input type="radio"/> Type 1 (Individual) <input type="radio"/> Type 2 (Group)</p>
--	---

Next

2. Select **Name**, **Office Physical Address** and **Other Provider Updates** to see the information that must be verified.

If you are verifying multiple locations:

- You must submit the form for each location.
- Select **Name**, **Office Physical Address** and **Other Provider Updates** for your first submission.
- For your next submissions, you won't need to select **Name** or **Other Provider Updates**.

When complete, select **Next**.

Change Existing Demographic Information

Type of Change

Name
 NPI/Tax
 Office Physical Address
 Billing Address
 Credentialing Address
 Administrative Address
 Other Provider Updates

Back **Next**



3. Verify name.

Individual Providers: Fill in the **Name** fields.

Group/Clinic or Facility/Ancillary: Fill in **Current Practice Name**.

For **Effective Date of Change**:

- When **verifying data**, fill in **today's date**.
- When **changing data**, fill in **date of change**.

Select **Next** when complete.

Change Existing Demographic Information

Name Change

* Indicates required field

Attach signed and dated W-9 for name change. If you have multiple titles please list additional titles in the below comments box.

Current Name	New Name
First Name: <div style="border: 1px solid #0070C0; border-radius: 5px; padding: 2px;">Individual Provider</div>	First Name: <input style="width: 90%; border: none; border-bottom: 1px solid #ccc;" type="text"/>
Middle Name <input style="width: 90%; border: none; border-bottom: 1px solid #ccc;" type="text"/>	Middle Name: <input style="width: 90%; border: none; border-bottom: 1px solid #ccc;" type="text"/>
Last Name: <input style="width: 90%; border: none; border-bottom: 1px solid #ccc;" type="text"/>	Last Name: <input style="width: 90%; border: none; border-bottom: 1px solid #ccc;" type="text"/>
Suffix: <input style="width: 90%; border: none; border-bottom: 1px solid #ccc;" type="text"/>	Suffix: <input style="width: 90%; border: none; border-bottom: 1px solid #ccc;" type="text"/>
Current Title: <input style="width: 90%; border: none; border-bottom: 1px solid #ccc;" type="text"/>	New Title: <input style="width: 90%; border: none; border-bottom: 1px solid #ccc;" type="text"/>
Current Practice Name: <div style="border: 1px solid #0070C0; border-radius: 5px; padding: 2px;">Group/Clinic/Facility/Ancillary</div>	New Practice Name: <input style="width: 90%; border: none; border-bottom: 1px solid #ccc;" type="text"/>

Additional Information

Comments:

* Effective Date of Change:

Attach Documentation:

Note: combined file sizes cannot exceed 25MB. File formats accepted: bmp, doc, docx, gif, jpeg, jpg, zip, pdf, png, txt, xls, .xlsx. User can select only up to 5 total files per request type.

Combined file size = 0.0 MB

Choose File

No file chosen

+

Add another file

Back

Next



4. Verify office physical address.

Fill in the office **Address, City, State, ZIP code, Telephone Number** and **Email**.

Fill in today's date for **Effective Date of Change** if you're verifying information.

Select **Next** when complete.

Change Existing Demographic Information

Office Physical Address/Telephone/Fax/Email/Hours of Operation Change
* Indicates required field

Complete a separate form for each office physical address change request. This information is utilized for the member directories. A P.O. Box address will not be accepted as an official physical address. If your primary address change involves moving to a different county, this could impact your claims payment.

<p>Current Office Physical Address</p> <p>Address Line 1: _____</p> <p>Address Line 2: _____</p> <p>City: _____</p> <p>State: Zip Code: _____</p> <p>Telephone Number: Ext: <small>Numeric digits only.</small> <small>Numeric digits only.</small></p> <p>Email: <small>you@example.com</small></p> <p>Fax Number: <small>Numeric digits only. For example: 1234567890</small></p>	<p>New Office Physical Address</p> <p>Address Line 1: _____</p> <p>Address Line 2: _____</p> <p>City: _____</p> <p>State: Zip Code: _____</p> <p>Telephone Number: Ext: <small>Numeric digits only.</small> <small>Numeric digits only.</small></p> <p>Email: <small>you@example.com</small></p> <p>Fax Number: <small>Numeric digits only. For example: 1234567890</small></p>
---	---

Additional Information

Comments:

* Effective Date of Change:

Attach Documentation:
Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.

Combined file size = 0.0 MB

No file chosen

Add another file

Back

Next



5. Verify specialty and submit form.

Under **Other Provider Updates**, fill in **Specialty**. It is the only data in this section that must be verified.

If verifying information, fill in today's date for **Effective Date of Change**.

When complete, select **Submit Form**.

You will receive a case number confirming you've verified or changed your data after you submit the form.

Change Existing Demographic Information

Other Provider Updates

** Indicates required field*

Current Information	New Information
Hospital Privilege (list all): _____	Hospital Privilege (list all): _____
Ambulatory Surgery Center Privileges (list all): _____	Ambulatory Surgery Center Privileges (list all): _____
License Number: _____	License Number: _____
Specialty: _____	Specialty: _____
Subspecialty: _____	Subspecialty: _____
Specialty Effective Date: _____	Specialty Effective Date: _____
Specialty Certification Date: _____	Specialty Certification Date: _____
Board Certified: <input type="radio"/> Yes <input type="radio"/> No	Board Certified: <input type="radio"/> Yes <input type="radio"/> No
Provide Lactation Services: <input type="radio"/> Yes <input type="radio"/> No	Provide Lactation Services: <input type="radio"/> Yes <input type="radio"/> No
Medication Assisted Treatment	Date Of Birth: _____
Is Medication Assisted Treatment for Opioid Use Disorders provided at this location?	Languages (spoken or written): _____
<input type="radio"/> Yes <input type="radio"/> No	
Additional Information	
Comments: _____	* Effective Date of Change: _____
	Attach Documentation: Note: combined file sizes cannot exceed 25MB. File formats accepted: .bmp, .doc, .docx, .gif, .jpeg, .jpg, .zip, .pdf, .png, .txt, .xls, .xlsx. User can select only up to 5 total files per request type.
	Combined file size = 0.0 MB <input type="button" value="Choose File"/> No file chosen <input type="button" value="+ Add another file"/>
* <input type="checkbox"/> Provider/ Group has reviewed the information listed on the BCBSIL provider finder for accuracy and is hereby attesting that all other information is accurate.	
<input type="button" value="Back"/>	<input type="button" value="Submit Form"/>

By clicking this link, you will go to a new website/app ("site"). This new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. In addition, some sites may require you to agree to their terms of use and privacy policy.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.

Blue Cross®, Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.