



**BlueCross BlueShield  
of Vermont**

P.O. Box 186  
Montpelier, VT 05601



*Independent Licensees of the Blue Cross and Blue Shield Association.*

## PROVIDER ENROLLMENT CHANGE FORM (PECF)

### SECTION 1: REASON FOR FORM (Refer to instructions)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Add New Provider                        | <input type="checkbox"/> Patient Panel Change                               | <input type="checkbox"/> New Billing Group                                      |
| <input type="checkbox"/> Add/Terminate Location(s)               | <input type="checkbox"/> Accepting New Patients                             | <input type="checkbox"/> Physical Address Change                                |
| <input type="checkbox"/> Billing Address Change                  | <input type="checkbox"/> Closed to New Patients                             | <input type="checkbox"/> Provider Name Change <b>(Copy of license required)</b> |
| <input type="checkbox"/> Change tax ID <b>(W-9 required)</b>     | <input type="checkbox"/> Restrictions <b>(Indicate in comments section)</b> | <input type="checkbox"/> Terminate Provider                                     |
| <input type="checkbox"/> Group Name Change <b>(W-9 required)</b> |   | <input type="checkbox"/> Terminate Group  |

**If a primary care physician (PCP) is terminating, indicate the name of PCP members should be assigned to:**

Comments/Effective Date: \_\_\_\_\_

### SECTION 2: OFFICE AND BILLING ADDRESS

**Physical Address of practice:**

Is this the primary location?  Yes  No (See instructions)

NPI: \_\_\_\_\_  
 Group Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_  
 Fax Number: ( \_\_\_\_\_ ) \_\_\_\_\_

**Billing Address** (Note: All provider notifications, payments and remittances from BCBSVT/TVHP will be mailed to this address)

Group Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_  
 Fax Number: ( \_\_\_\_\_ ) \_\_\_\_\_

**Provider name and tax ID # must match those listed on the W-9 form**

Tax ID #: \_\_\_\_\_ **COPY OF W-9 AND LIABILITY INSURANCE REQUIRED**

### SECTION 3: PROVIDER INFORMATION

NPI: \_\_\_\_\_ CAQH ID #: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_ Degree/Title: \_\_\_\_\_  
 Date of Birth: \_\_ \_\_/\_\_/\_\_ Social Security Number: \_\_\_\_\_ Gender:  M  F  
 License #: \_\_\_\_\_ Hospital Affiliation(s): \_\_\_\_\_ Language(s) Spoken: \_\_\_\_\_  
**(copy required)**  
 DEA #: \_\_\_\_\_ Will the provider be prescribing, storing or dispensing any medications at above practice location?  Yes  No **If Yes, copy required**

**PCP** Accepting Patients:  Yes  No

Specialty: \_\_\_\_\_ Market in Directory:  Yes  No  
 Sub Specialty: \_\_\_\_\_ Board Certified:  Yes  No (Provide a copy of the certificate)

**Specialist**

Specialty: \_\_\_\_\_ Market in Directory:  Yes  No  
 Sub Specialty: \_\_\_\_\_ Board Certified:  Yes  No (Provide a copy of the certificate)

**Locum Tenen/Per Diem** (do not market)

How long will they be rendering services? \_\_\_\_\_

### SECTION 4: AUTHORIZATION

I certify that the above information is complete and accurate, and I agree, if a new provider is enrolling on this form, that the services the provider renders to Blue Cross and Blue Shield of Vermont (BCBSVT) members and members of BCBSVT's licensed affiliates will be provided according to the terms and conditions of the professional provider group contract, the physician-hospital organization contract, or the hospital contract (if provider is employed or contracted with a hospital), whichever is applicable, between such entity and BCBSVT and/or BCBSVT affiliate.

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

**If questions contact:** Name: \_\_\_\_\_ Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_



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## **Instructions for Completing the Provider Enrollment Change Form (PECF)**

Complete each section as it pertains. PECF will be returned unprocessed if information or signature is missing. If you have any questions on how to complete this form, call 1-888-449-0443. Mail completed PECF to the address above or fax to 802-371-3489.

**Note: If you credential through a Physician Hospital Organization (PHO), you must contact them in addition to completing this form.**

### **Section 1: Reason for Form**

Check the box(s) that indicate your reason(s) for completing this form.

- **Add New Provider** - Adding a new provider to the practice, complete all sections of the PECF.
- **Add/Terminate Location(s)** - Adding or terminating more than one location, complete a PECF for each location.
- **Billing Address Change** - We can only maintain one address, all mail from BCBSVT/TVHP will be mailed to this address.
- **Change Tax ID Number** - W-9 required.
- **Group Name Change** - Changing the name of the practice, W-9 required.
- **Patient Panel Change** - Check the appropriate box.
  - Accepting new patients will be effective as outlined in your provider contract.
  - Closing practice to new patients is effective 60 days from the date we receive the PECF.
  - Restrictions (Indicate any restrictions in the comments section eg. age).
- **New Billing Group** - Submit a W-9, copy of liability insurance and required contracts.
- **Physical Address Change** - When changing physical location of practice.
- **Provider Name Change** - Submit a copy of professional license.
- **Terminate Provider** - State reason for termination (eg. retired, moved out of state) and indicate effective date in comments section. If a PCP provider currently contracts with managed care and holds a patient panel, indicate name of the PCP to whom members should be assigned.
- **Terminate Group** - Indicate effective date in comments section.

### **Section 2: Office and Billing Address**

New groups having one or more providers associated with the practice must complete a PECF for the group and separate PECF for each provider associated with the practice. Complete in its entirety.

- **Physical Address** - This is the physical location of the office. Complete a PECF for each location added.
- **Billing Address** - We can only maintain one billing address per group/individual provider number, all mail from BCBSVT/TVHP will be mailed to this address.
- **National Provider Identifier (NPI)**

### **Section 3: Provider Information**

Complete this section if adding a new provider to the practice or if there is a change to the provider information. Complete in its entirety.

This section does not apply to: Durable Medical Equipment (DME), Home Health Agency (HHA), Infusion Therapy (IT) and Skilled Nursing Facility (SNF).

**To comply with the regulations, Blue Cross and Blue Shield of Vermont (BCBSVT) requires that contracted providers submit a copy of DEA registration for each state in which he or she prescribes, stores or dispenses medications.**

### **Section 4: Authorization**

- **Authorized signature and date required.**
- **Please provide contact information to assure accuracy of processing.**