Horizon Blue Cross Blue Shield of New Jersey

DENTAL OFFICE CHANGE REQUEST FORM

When completing an Office change or Provider change form for your office, please ensure when submitting these forms, there may be additional documentation required in order to support your request.

Please use the Office change form when submitting a change to our office address. i.e.: Tax Identification Change, Legal Name Change, Doing Business Name Change or address change. This change will be applied to all current providers listed with the office.

Please use a Provider Change form when submitting a change to a provider. . i.e.: Adding a provider to a location(s), specialty change, updating a provider's license, name or individual NPI. Etc. This change will be applied to only the provider listed on the Provider Change form.

W9 must be current, signed/dated and included with the following requests:

- Adding a TIN that is not already associated with Horizon
- Tax Identification Number change
- Legal Name change

Specialty Certification identifying if provider is board certified or eligible must be submitted when:

- Changing a provider's specialty

If you are **adding a provider to a location** and they are not already contracted with a specific network, a contract may be required. Please contact your Network Representative at Horizon to confirm.

If you are **adding a new provider** that is not already participation with Horizon, please contact your Network Representative at Horizon at 973-466-5133 to obtain a full credentialing packet and appropriate contract(s). Please do not fill out this form.

In the event there is a **change in ownership or dissolution of a partnership**, please contact your Network Representative at Horizon.

IMPORTANT:

The provider's license number and name listed on the change forms should be listed as you submit on your claim form to avoid any delay in claims payments.

The office address listed on the change forms should be listed as you submit on your claim form to avoid any delay in claims payments.

Clear Form

Horizon Blue Cross Blue Shield of New Jersey

Dental Office Change Request Form

If your request is to change your provider's information, please refer to the **Provider change form**. This form is to be used for all changes related to an office address and applies to all current providers listed at the office. Form must be signed and dated in order to be considered complete, if any information is missing, we will contact your office for additional information. *Submit a signed/dated W9 where the (*) indicates.

SECTION I OFFICE INFORMATION:

TIN: _____ IRS Name: _____
(Tax Identification Number used when submitting claims) *(Name as registered with the IRS)*

Office Name: _____
*(**Doing Business As,** if different than IRS name, please indicate)*

Office Address: _____
(Address, bldg., ste #, City, ST, Zip) Address listed here must be used when submitting a claim

Phone: _____ Fax: _____

Please Indicate Change(s) Below:

Please note: *If the owner of the office is changing or there is dissolution of a partnership, please contact Horizon at 973-466-5133 to assist you.*

☐ **TIN Change - New TIN:** _____ Effective Date of new TIN:_____
(Attach a current ***W9 signed and dated**)

☐ **Office Change** – What is changing?
☐ IRS Name (attach a current ***W9 signed and dated**) ☐ Office Name ☐ Phone/Fax/Email/NPI/Other

New Office Name: _____

Phone: _____ Fax: _____

Email: _____ Web Address:_____

Clinic NPI: _____ Corporate NPI: _____
(Please provide your entity type 2 NPI)

☐ **Address Change** – Which Address is changing? (Please complete full address, city, state and zip)
☐ Office Address ☐ Billing Address ☐ Correspondence Address

New Office Address: _____
(Address, bldg., ste #, City, ST, Zip) - Address listed here must be used when submitting a claim

New Billing Address: _____
(Address, bldg., ste #, City, ST, Zip)

New Correspondence Address _____
(Address, bldg., ste #, City, ST, Zip)

Effective Date of new address: _____

☐ Other (please indicate change to clinic): _____

For your convenience, we have provided you with a mail to address. Please sign, date and return the form to one of the contacts below:

Mail To: Horizon Blue Cross Blue Shield of NJ Dental Programs
Attn: Provider File Maintenance
3 Penn Plaza East PP-03H
Newark, NJ 07105
Fax: (973) 274-2202

By signing this form, you are an authorized signee on behalf of the practice and attest that the information contained in this form is accurate and correct. ***Form must be signed and dated on both lines in order to process any of the requested changes.***

Signature: _____ Please Print:_____

Date:_____

Clear Form

Horizon Blue Cross Blue Shield of New Jersey

Provider Change Request Form

If your request is to change the office information only, please refer to the **Dental Office change form**. This form is to be used for all changes related to a provider, please complete **Section 1** Office Information and **Section II:** Provider Information.

Form must be signed and dated in order to be considered complete, if any information is missing, we will contact your office for additional information. *Submit a signed/dated W9 where the (*) indicates. ** Submit your board certification / eligibility if you are a specialist

SECTION I OFFICE INFORMATION:

TIN: _____ IRS Name: _____
(Tax Identification Number used when submitting claims) *(Name as registered with the IRS)*

Office Name: _____
*(**Doing Business As,** if different than IRS name, please indicate)*

Office Address: _____
(Address, bldg., ste #, City, ST, Zip) Address listed here must be used when submitting a claim

Phone: _____ Fax: _____
Only required if you are adding a new office)

Billing Address: _____
(Only required if you are adding a new office) *(Address, bldg., ste #, City, ST, Zip)*

Correspondence Address: _____
(Only required if you are adding a new office) (Address, bldg., ste #, City, ST, Zip)

Please Indicate Change(s) Below:

Please note: *If the owner of the office is changing or there is dissolution of a partnership, please contact Horizon at 973-466-5133 to assist you.*

☐ **Add New Location** Effective Date of new Office: _____
(Office information above is required, along with provider information in section II. If you are adding more than one location and/or provider, please complete additional forms and attached a current *** W9 signed/dated.**)

SECTION II PROVIDER INFORMATION:

Last Name _____ First Name: _____ MI_____

License Number: _____
(License # listed here must be used when submitting claims)

** Specialty: NPI: _____
(Type 1 Individual NPI)

Are you an owner, partner or associate of the office location above? ☐ Owner ☐ Partner ☐ Associate

Please indicate request below:

☐ **Add Provider to office Address identified in Section 1**
(If a provider is not currently participating with Horizon, contract 973-466-5133 for assistance on what is required in order to add your provider.)

☐ **Provider Change:** ☐ Name Change ☐ License Change ☐ ** Specialty Change ☐ Other

New Name: _____
(First / MI / Last Name)

New License: _____
(License # listed here must be used when submitting claims)

Specialty Change to:

Other (please indicate change): _____

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Attn: Provider File Maintenance
3 Penn Plaza East PP-03H
Newark, NJ 07105
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Signature: _____ Please Print:_____

Date:_____