BlueCross BlueShield of New Mexico

P.O. Box 660058
ATTN: Network Services
Dallas, TX 75266-0058
Fax: (505) 816-2688 or 1-866-290-7718

Request to Establish or Revise a Non-Contracted Provider Record

Please check one:

☐ **Establishing a new provider record**

Please complete the entire form.

☐ **Revising an existing provider record**

Please provide your name, any information that you wish to change, and your signature.

NOTE: If this is a group practice, please complete a separate form for each individual.

Provider Name (Title/Degree): ______________________________

Social Security #: ____________________ Date of Birth: ____________________

Federal Tax ID # (TIN or EIN): ____________________ (If TIN change, effective date of new TIN) ____________________

*Type 1 Individual NPI (National Provider Identifier) #: ______________________________

Business or Group Name: ____________________ Type 2 NPI# ____________________

***Effective date of joining group**: ______________________________

Your license indicates you are certified as: ______________________________

License #: ____________________ State: ____________________

Primary Specialty: ______________________________

Secondary Specialty: ______________________________

Physical Address: ______________________________

City, State, Zip: ____________________ *Effective Date: ____________________

Phone: ____________________ Fax: ____________________

Note: Please attach a separate sheet for any additional locations.

Mailing Address:

Business or Group Name: ______________________________

Street Name: ______________________________

City, State, Zip: ______________________________

Phone: ____________________ Fax: ____________________

Billing Address:

Business or Group Name: ______________________________

Street Name: ______________________________

City, State, Zip: ______________________________

Phone: ____________________ Fax: ____________________

*Make Payment Payable to: ______________________________

*Federal Tax ID #: ____________________ *IRS Legal Entity Name: ____________________

Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) must be reported exactly as recorded with the IRS.
Please complete and return the IRS 147C letter with this questionnaire

______________________________ ____________________ ____________________

Signature of person completing this form | Date | Phone No.

*REQUIRED FIELDS

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association