



DENTAL PROVIDER CHANGE NOTICE

Clinic Name: _____

Dentist Name: _____
Last First

Provider TIN #: _____ - _____ NPI: _____

Is this a new TIN? Yes No

(If yes, please include a completed W-9 form) Group NPI: _____

Address Information: New Address Additional Location

BILLING ADDRESS

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____

SERVICE ADDRESS

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____

Effective Date of Change ____ / ____ / ____

Please fax the completed form to:
Dental Services – Provider Relations
Fax Number - (208) 286-3575

Or mail completed form to:
Blue Cross of Idaho – Dental Services
P.O. Box 7408
Boise, ID 83707

For More Information Contact Dental Customer Service
1-800-289-7929 or (208) 363-8755 • www.bcidaho.com

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