BlueCross BlueShield of Western New York
MEDICAID | CHILD HEALTH PLUS

Medicaid Managed Care
Child Health Plus

Practice Profile Update Form

BlueCross BlueShield of Western New York (BlueCross BlueShield) partners with Amerigroup companies to administer certain services to Medicaid Managed Care (MMC) and Child Health Plus (CHPlus) members. Please note this correspondence is specific to the MMC and CHPlus programs only.

To update your practice profile, send new information using the form below to the Provider Relations department via email to wnynetworkproviderrelations@amerigroup.com. If you have any questions or need assistance, please contact your local Provider Relations representative or call **1-866-231-0847**.

1. Do not complete the entire form; only fill in sections where your information has changed.
2. You must complete the **Provider information** section.
3. Sign and date the form before faxing.

Provider information			
Provider name:		Specialty:	
License number:		NPI:	
Provider email:			Gender: ☐ Female ☐ Male

What type of information are you updating?

Please check all that apply.

☐ Practice details
☐ Primary care provider details
☐ Billing information
☐ New or an additional office location
☐ Remove an office location
☐ Other: _____

Practice details

Office hours:	From:	To:
Monday	_____ a.m.	_____ p.m.
Tuesday	_____ a.m.	_____ p.m.
Wednesday	_____ a.m.	_____ p.m.
Thursday	_____ a.m.	_____ p.m.
Friday	_____ a.m.	_____ p.m.
Saturday	_____ a.m.	_____ p.m.
Sunday	_____ a.m.	_____ p.m.

Age range of patients served:
☐ Pediatric ☐ Geriatric
☐ All ages ☐ Other: _____

Languages spoken: _____

Wheelchair accessible? ☐ Yes ☐ No

Primary care provider details

Primary care providers are **required** to have coverage 24 hours a day, 7 days a week. Please mark your coverage type below.

☐ Answering service ☐ Beeper or pager ☐ Answering machine

☐ Other phone number: _____

Are you accepting new patients? ☐ Yes ☐ No

If no, please explain: _____

www.bcbswny.com/stateplans

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Billing information Please attach a copy of the current *W-9* form for all billing information changes.		
New tax ID number? ☐ Yes ☐ No	Tax ID number:	
Billing address:		
Contact person:		
City:	State:	Zip:
Phone number:	Fax number:	
New or an additional office location		
☐ New location ☐ Additional location		
Site name:		
Site address:		
City:	State:	Zip:
Office manager:		
Phone number:	Fax number:	

Office hours:	From:	To:	Age range of patients served: ☐ Pediatric ☐ Geriatric ☐ All ages ☐ Other: _____ Languages spoken: _____ Wheelchair accessible? ☐ Yes ☐ No
Monday	_____ a.m.	_____ p.m.	
Tuesday	_____ a.m.	_____ p.m.	
Wednesday	_____ a.m.	_____ p.m.	
Thursday	_____ a.m.	_____ p.m.	
Friday	_____ a.m.	_____ p.m.	
Saturday	_____ a.m.	_____ p.m.	
Sunday	_____ a.m.	_____ p.m.	

Remove an office location		
Site name:		
Site address:		
City:	State:	Zip:
Office manager:		
Phone number:	Fax number:	
To add or remove additional office locations, attach a separate sheet.		

Please sign and date

Signature: _____ Printed name: _____

Contact phone number: _____ Date completed: _____

For office use only

Date received by BlueCross BlueShield: _____