Change of Address Form

Use this form to update your physical, pay to, correspondence and/or billing agency addresses for Preferred Blue®, BlueChoice HealthPlan, Healthy Blue℠, State Health Plan, and FEP networks.

Note: If you are changing a pay to address, the provider or the CEO, CFO, director of finance, or director of billing must sign this form for your protection.

Name: ____

Tax ID Number: ________________________

NPI Number: ________________________

Effective Date: ________________________

Phone Number: ________________________

Old Physical Address:

____

____

Phone Number: __________________________

Fax number: _____________________________

New Physical Address:

____

____

Phone Number: __________________________

Fax number: _____________________________

Old Pay to Address:

____

____

Phone Number: __________________________

Fax number: _____________________________

New Pay to Address:

____

____

Phone Number: __________________________

Fax number: _____________________________

Old Correspondence Address:

____

____

Phone Number: __________________________

Fax number: _____________________________

New Correspondence Address:

____

____

Phone Number: __________________________

Fax number: _____________________________

BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan are independent licensees of the Blue Cross and Blue Shield Association.
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Old Billing Agency:

____

____

Phone Number: _________________________

Fax number: ____________________________

New Billing Agency:

____

____

Phone Number: _________________________

Fax number: ____________________________

Signature: _______________________________________

Printed Name: _______________________________________

Organization Affiliation: _______________________________________

Title: _______________________________________ Date: ________________________

Email Address (required for notification): ____

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