Provider Group/Facility Information Change Form (ICF-02)

The data provided on this form or an additional form with equivalent data is used by Blue Shield of California (Blue Shield) and/or Blue Shield of California Promise Health Plan (Blue Shield Promise) to add, change, or remove information on an established provider group or facility record. Blue Shield and/or Blue Shield Promise will confirm that the request has been processed.

Instructions

Identify the provider group or facility requiring changes by populating the Business Name/dba, Tax Identification Number(TIN), and National Provider Identifier (NPI) fields. Complete all applicable fields that require changes. Attach all required documentation, as outlined below, and return this form to Blue Shield and/or Blue Shield Promise via email at BSCProviderInfo@blueshieldca.com. This form may be completed electronically.

Changes to Roster Practitioners

To add/change/remove a roster member, refer to the instructions on the roster page of this form.

Copies of roster pages can be used to send an update for additional practitioners.

Required Documentation

This request will not be initiated until all the required documentation, as indicated below, is received by Blue Shield and/or Blue Shield Promise. Failure to provide the required documentation will result in no action being taken.

For changes to your corporation or business structure: Please submit the Articles of Incorporation with this form.

- For changes to your employer identification number (EIN) or tax identification number (TIN), please submit a signed W-9 or Department of Treasury/Internal Revenue Service (IRS) tax document.
- Changes to facility locations may require a current location license number. The request must be on the provider organization letterhead and include an authorized signature.
- For all other changes to your information, no supporting documentation is required.

Additional Information

This form is only used to update existing provider group or facility records. To create a new provider group or facility record, please complete the Provider Group/Facility Record Application (Form RA- 02). This form is not an agreement to participate in the Blue Shield and/or Blue Shield Promise provider network. For information about joining either network, please contact our Provider Information and Enrollment Department via email at BSCProviderInfo@blueshieldca.com

In accordance with regulatory requirements, Blue Shield reports and publishes a maximum number of in-person service locations for practitioners:

Primary Care Physicians (PCPs)

One practitioner may not be listed as a primary care physician (PCP) in more than seven (7) in-person service location addresses across the entire network. This requirement applies even if the practitioner is listed as a PCP on rosters for multiple, separately contracted IPA/medical groups. The aggregated total for providing in-person services as a PCP must not exceed seven (7) service locations in Blue Shield's entire provider directory.

Physician Specialists

One physician specialist may not be listed as a specialist in more than eleven (11) in-person service location addresses across the entire network. This requirement applies even if the practitioner is listed as a specialist on rosters for multiple, separately contracted IPA/medical groups. The aggregated total for providing in-person services as a specialist must not exceed eleven (11) service locations in Blue Shield's entire provider directory. The above limitation requirements only apply to in-person service locations for each PCP or specialist practitioner.

No limits apply to locations where ONLY telehealth or virtual care services ONLY are provided by the PCP or specialist. If the practitioner also provides services to Blue Shield members in person at the location, however, it will be counted as an in-person services location.

Provider Group/Facility Information Change Form (ICF-02), cont'd.

By submitting this form applicant certifies on behalf of this provider record that all information included on this form is true, accurate and complete. Any false statements, the concealment of material fact, or the use of false documents may lead to prosecution under applicable federal or state laws. Applicant certifies under penalty of perjury that the foregoing is true and correct. To **ADD** information, check the **ADD** box and use the **NEW** column. To **CHANGE** information, check the **CHANGE** box and use the **EXISTING** and **NEW** columns. To **REMOVE** information, check the **REMOVE** box and use the EXISTIG column. *Indicates required field.

Identify the provider group record requiring changes:

Business name/dba:*	
Tax identification number (TIN):*	
National provider identifier (NPI):*	

Identify the specific changes needed for the group:

Add	Change	Remove	Information	Existing	New
			Business name/dba		
			Primary specialty/type of service		
			TIN (attach pre-printed tax document or W-9 form)		
			NPI		
			License number		
			Service location address		
			Appointment phone number (required for new locations)		
			Fax number		
			After hours phone number		
			Wheelchair access?	☐ Yes ☐ No	☐ Yes ☐ No
			Patient visit options (check all that apply)	Telehealth visits ☐ In-person visits ☐	Telehealth visits ☐ In-person visits ☐
			Business email for Blue Shield's administrative use		
			Office days and hours	Sun Mon Tues Wed / Thurs Fri Sat	Sun Mon Tues Wed / Thurs Fri Sat
			Qualified medical interpreter	☐ Cantonese ☐ Spanish ☐ Korean ☐ Vietnamese ☐ Mandarin ☐ N/A ☐ Russian	☐ Cantonese ☐ Spanish ☐ Korean ☐ Vietnamese ☐ Mandarin ☐ N/A ☐ Russian
			Clinical staff language(s)		
			Billing address		
			Billing phone number		
			Billing fax number		

Provider Group/Facility Information Change Form (ICF-02), cont'd.

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Business name/dba:*	
Tax identification number (TIN):*	
Service location address:*	
Service location appointment phone number:*	

Identify changes to your practitioner roster:

Changes to Roster Practitioner 1					
Add	**Change**	**Remove**	**Information**	**Existing**	**New**
			Licensed practitioner's name		
			Title		
			Gender		
			Degree		
			Specialty		
			License number		
			Social security number (SSN)		
			NPI		
			Supervising physician name (if applicable)		
			Supervisor's NPI		
			Language(s) spoken		
			Ethnicity		
			Patient acceptance	Gender and patient limitations:	Gender and patient limitations:
				☐ N/A	☐ N/A
				☐ Male only	☐ Male only
				☐ Female only	☐ Female only
				☐ Current patients only	☐ Current patients only
				☐ New and existing patients	☐ New and existing patients
				Lowest age:	Lowest age:
				Highest age:	Highest age:
			Hospital based practitioner?	☐ Yes ☐ No	☐ Yes ☐ No
			Hospital affiliation name(s)		

* Required fields

Provider Group/Facility Information Change Form (ICF-02), cont'd.

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Business name/dba:*	
Tax identification number (TIN):*	
Service location address:*	
Service location appointment phone number:*	

Identify changes to your practitioner roster:

Changes to Roster Practitioner 2					
Add	**Change**	**Remove**	**Information**	**Existing**	**New**
			Licensed practitioner's name		
			Title		
			Gender		
			Degree		
			Specialty		
			License number		
			Social security number (SSN)		
			NPI		
			Supervising physician name (if applicable)		
			Supervisor's NPI		
			Language(s) spoken		
			Ethnicity		
			Patient acceptance	Gender and patient limitations:	Gender and patient limitations:
				☐ N/A	☐ N/A
				☐ Male only	☐ Male only
				☐ Female only	☐ Female only
				☐ Current patients only	☐ Current patients only
				☐ New and existing patients	☐ New and existing patients
				Lowest age:	Lowest age:
				Highest age:	Highest age:
			Hospital based practitioner?	☐ Yes ☐ No	☐ Yes ☐ No
			Hospital affiliation name(s)		