

## Change of Address Form

Use this form to update your Physical Pay To, Correspondence and/or Billing Agency addresses for Preferred Blue®, BlueChoice HealthPlan, BlueChoice HealthPlan Medicaid, the State Health Plan and FEP networks. 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.

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Name: \_\_\_\_\_

Tax ID # NPI #: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Old Physical Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

New Physical Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Old Pay To Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

New Pay To Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Old Correspondence Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

New Correspondence Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Old Billing Agency:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

New Billing Agency:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE: \_\_\_\_\_

TITLE: \_\_\_\_\_ DATE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

(required for notification when we complete changes)

Please fax the completed form to Provider Certification at 803-264-4795. If you have questions about the form, email [Provider.Cert@bcbssc.com](mailto:Provider.Cert@bcbssc.com).