



An Independent Licensee of the Blue Cross and Blue Shield Association

FOR HMSA USE ONLY

# ADDRESS CHANGE FORM

To close an existing practice location and move to a new practice location. Use this form if you're moving to a different practice location but still receiving payments with the same tax ID.

## REQUIRED INFORMATION

Provider Name: \_\_\_\_\_ Social Security Number (last four digits only): \_\_\_\_\_

National Provider Identifier (NPI) Number: \_\_\_\_\_ HMSA Provider ID Number: \_\_\_\_\_  
(Indicate your individual NPI, not your clinic's or group's NPI.)

## PRACTICE LOCATION (Indicate the physical address; no PO Boxes.)

Don't list this location in HMSA's directories.

\*EFFECTIVE DATE: \_\_\_\_\_

Old Practice Location Address:  
\_\_\_\_\_  
\_\_\_\_\_

New Practice Location Address:  
\_\_\_\_\_  
\_\_\_\_\_

Is this your primary practice location?  Yes  No, my primary location is: \_\_\_\_\_

If you're a participating provider, check all of the boxes that apply to this location:

	Accepting New Patients	Established Patients Only	Not Accepting New Patients
PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MEDICARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
QUEST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VA Network <sup>(1)</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(1) Veterans Affairs Patient-Centered Community Care

Appointment Phone Number: \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_  
(Will be published in HMSA directories.) (Will be published in HMSA directories if Appointment Phone Number isn't provided.)

Fax Number: \_\_\_\_\_ Fax Number (referrals): \_\_\_\_\_ Email Address: \_\_\_\_\_

Office Manager Name: \_\_\_\_\_ Office Manager's Phone Number: \_\_\_\_\_

Would you like to receive notifications, memos, and letters via the email address provided above?  Yes  No

## PHYSICIAN ASSISTANT INFORMATION (Please complete if applicable.)

Name of supervising physician at this location: \_\_\_\_\_

## MAILING ADDRESS (Complete only if your mailing address has changed. The mailing address you indicate here will be applied to all of your practice locations.)

Address: \_\_\_\_\_ \*EFFECTIVE DATE: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

\* A future effective date (MM/DD/YY) is required to complete this request. If you leave any applicable Effective Date fields blank, we'll use the effective date you wrote elsewhere on the form. If you don't provide an effective date anywhere on the form, your request may be delayed.



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**OTHER OFFICE INFORMATION** (Please complete if applicable. If there are no changes, leave blank.)

Number of office staff (including provider): \_\_\_\_\_ Number of staff who speak languages other than English: \_\_\_\_\_

Languages spoken (check all that apply):

- |   |  |   |   |
|---|--|---|---|
| <b>Provider/Staff</b>   | <b>Provider/Staff</b>  | <b>Provider/Staff</b>   | <b>Provider/Staff</b>                                     |
| <input type="checkbox"/> / <input type="checkbox"/> Cantonese | <input type="checkbox"/> / <input type="checkbox"/> Japanese | <input type="checkbox"/> / <input type="checkbox"/> Tagalog       | <input type="checkbox"/> / <input type="checkbox"/> Other |
| <input type="checkbox"/> / <input type="checkbox"/> French    | <input type="checkbox"/> / <input type="checkbox"/> Korean   | <input type="checkbox"/> / <input type="checkbox"/> Thai          | _____   |
| <input type="checkbox"/> / <input type="checkbox"/> German    | <input type="checkbox"/> / <input type="checkbox"/> Mandarin | <input type="checkbox"/> / <input type="checkbox"/> Tongan        | _____   |
| <input type="checkbox"/> / <input type="checkbox"/> Hawaiian  | <input type="checkbox"/> / <input type="checkbox"/> Samoan   | <input type="checkbox"/> / <input type="checkbox"/> Vietnamese    | _____   |
| <input type="checkbox"/> / <input type="checkbox"/> Ilocano   | <input type="checkbox"/> / <input type="checkbox"/> Spanish  | <input type="checkbox"/> / <input type="checkbox"/> Sign Language | _____   |

Does this practice location have access to interpreter services?  Yes  No

Is this location accessible to people with disabilities?  Yes  No

Office Hours	MON	TUES	WED	THURS	FRI	SAT	SUN

**PAYMENT INFORMATION**

**IMPORTANT NOTE:** If your payment information (remittance address, payment address, payee, etc.) has also changed, please complete the **Payment Change Form** and submit it with this form.

**PROVIDER SIGNATURE** (signature & date is required to process request)

If I have signed this Address Change Form electronically, it means I acknowledge and agree to the terms of this Address Change Form and so indicate by typing my name below as my electronic signature, executed and adopted by me with the intent to sign this document [- in other words, typing my name as an electronic signature indicates I acknowledge and agree to the terms of this form just as a handwritten signature would on a traditional paper form].

Signature \_\_\_\_\_ Date \_\_\_\_\_

**SEND COMPLETED FORMS TO:**

<b>Mail</b>	Provider Data Administration, Room 509 HMSA P.O. Box 860 Honolulu, HI 96808-0860	<b>Email</b>	provider_data@hmsa.com
		<b>Fax</b>	948-8210 on Oahu
		<b>Phone</b>	952-7847 on Oahu or 1 (800) 603-4672 X7847 toll-free on the Neighbor Islands