



An Independent Licensee of the Blue Cross and Blue Shield Association

PAYMENT CHANGE FORM

For changes to your (check all that apply):

- Tax ID Number
- NPI Number
- Payment Address

FOR HMSA USE ONLY

IMPORTANT NOTES: *If your payment change includes a new practice location, please complete the **Additional Location Form** and submit it with this form. If you change your tax ID number or national provider identifier (NPI) number, we'll terminate your current HMSA provider ID number and issue you a new provider number. The changes you make here apply to all lines of business with which you're currently contracted for at the specified locations.*

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.)

NEW PAYMENT TAX ID# AND/OR NPI INFORMATION (Please complete if applicable. If there are no changes, leave blank.)

Name of Entity, Clinic or Group Practice: _____ *EFFECTIVE DATE: _____

What's your affiliation with the entity, clinic or group? Owner Employed Contracted

Federal Tax ID Number: _____ NPI NUMBER: _____

TYPE 1 TYPE 2

Please submit a new W-9 form with your payment change request.

NEW PAYMENT ADDRESS (Please complete if applicable. If there are no changes, leave blank.)

Address: _____ *EFFECTIVE DATE: _____

City: _____ State: _____ ZIP: _____

NEW PAYMENT INFORMATION (Please complete if applicable. If there are no changes, leave blank.)

Make checks out to:

Self Entity Clinic Group: _____ *EFFECTIVE DATE: _____

Other† (specify): _____

Mail check to:

New Payment Address: _____

Practice Location Address: _____

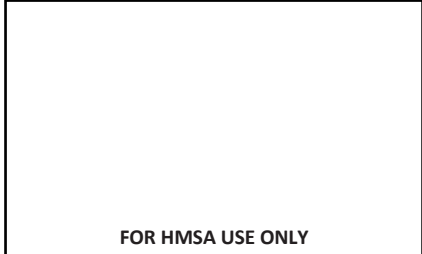
Mailing Address: _____

Other Address (specify): _____

List all HMSA provider ID numbers that changes to payment information should be applied to:

* 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.

† Indicate the provider's name and federal tax ID number or social security number.



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

If I have signed this Payment Change Form electronically, it means I acknowledge and agree to the terms of this Payment 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:

Mail Provider Data Administration, Room 509
 HMSA
 P.O. Box 860
 Honolulu, HI 96808-0860

Email provider_data@hmsa.com
Fax 948-8210 on Oahu
Phone 952-7847 on Oahu or 1 (800) 603-4672 X7847
 toll-free on the Neighbor Islands