



## Notification of Covering Provider

### I. Instructions

This form should be **typed or legibly printed in black ink.**

Use this form to add or delete covering provider information for Regence BlueShield **Participating** Providers. It is not necessary to fill out this form for Primary Care Providers Practicing under the same tax identification number.

**Note: Locum Tenens and Temporary Providers are excluded. See your provider manual for information on these provider types.**

Send the Completed Form w/ attachments to:

**Regence BlueShield  
Provider Network Management  
PO Box 21267 M/S 916  
Seattle, WA 98111-3267**

Or fax the Completed Form w/ Attachments to:

**Regence BlueShield  
Provider Network Management  
(888) 289-1313**

If you have any questions, contact Regence BlueShield Provider Network Management at 1-800-562-2156.

### II. Covering Provider Information

Last Name:	First:	Middle:
Tax Identification Number:	Rider Number:	Effective Date:
Additional Providers Included in this Change:		

### III. Provider Requesting Change

Provider Name:	Tax Identification:		
Clinic Name (if applicable):	Address:	City:	
Date:	Provider Signature:		