Healthy Blue

Medicaid Managed Care

Practice Profile Update Form

To update your practice profile, use this form to fax new information to the Provider Data Management department at **1-888-375-5063** or email the completed form to lainterpr@healthybluela.com. If you have any questions or need assistance, please contact your local Provider Relations representative at **1-504-836-8888**.

- Only fill in sections where your information has changed.
- You must complete the ***Provider information*** section.
- Sign and date the form before faxing.

Provider information

Provider name: _____

Provider type: ☐ PCP ☐ Specialist

Gender: ☐ Female ☐ Male

Specialty: _____

License number: _____

Provider NPI: _____

Group NPI: _____

Taxonomy number: _____

What type of information are you updating? *Check all that apply*.

☐ Billing information
☐ Location or contact information
☐ Office hours
☐ Practice details
☐ Primary care provider details
☐ Other: _____

Practice details

Office hours:

Monday	_____ a.m.	_____ p.m.
Tuesday	_____ a.m.	_____ p.m.
Wednesday	_____ a.m.	_____ p.m.
Thursday	_____ a.m.	_____ p.m.
Friday	_____ a.m.	_____ p.m.
Saturday	_____ a.m.	_____ p.m.
Sunday	_____ a.m.	_____ p.m.

Age range of patients served:
☐ Pediatric ☐ Geriatric _____
☐ 0 to 21 ☐ 21 and older
☐ All ages ☐ Other: _____

Languages spoken: _____

Wheelchair accessible? ☐ Yes ☐ No

Primary care provider details

Primary care providers are ***required*** to have coverage 24/7. Please mark your coverage type:

☐ Answering service ☐ Answering machine

☐ Other phone number: _____

Are you accepting new patients? ☐ Yes ☐ No

If yes, please explain (for example, at all locations): _____

Do you have *Clinical Laboratory Improvement Amendments (CLIA)* certification? ☐ Yes ☐ No

If yes, please provide level of certification, *CLIA* certification number, and effective and expiration dates:

_____

Billing information — *Attach a copy of your current* W-9 *for all billing information changes.*

Healthy Blue is the trade name of Community Care Health Plan of Louisiana, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

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New/additional office location(s)

☐ New location ☐ Additional location

Site name: _____

Site address: _____

Office manager/email address: _____

Phone number: _____

Fax number: _____

Office hours:

Monday	_____ a.m.	_____ p.m.
Tuesday	_____ a.m.	_____ p.m.
Wednesday	_____ a.m.	_____ p.m.
Thursday	_____ a.m.	_____ p.m.
Friday	_____ a.m.	_____ p.m.
Saturday	_____ a.m.	_____ p.m.
Sunday	_____ a.m.	_____ p.m.

Age range of patients served:

☐ Pediatric ☐ Geriatric: _____

☐ 0 to 21 ☐ 21 and older

☐ All ages ☐ Other: _____

Languages spoken: _____

Wheelchair accessible? ☐ Yes ☐ No

Remove an office location

Do you want to remove an office location? ☐ Yes ☐ No

Site name: _____

Site address: _____

Office manager: _____

Phone number: _____

Fax number: _____

To add or remove additional office locations, attach a separate sheet.

Signature: _____

Printed name: _____

Contact phone number: _____

For office use only

Date completed: _____

Date received by Healthy Blue: _____