Healthy Blue

Medicaid Managed Care

Practice Profile Update Form

To update your practice profile, send new information using the form below to the Provider Relations department via email to laoperations@healthybluela.com. If you have any questions or need assistance, please contact your local Provider Relations representative or call **1-844-521-6942**.

1. Do not complete the entire form; only fill in sections where your information has changed.
2. You must complete the **Provider information** section.
3. Sign and date the form before faxing.

Provider information		
Provider name:	Specialty:	
License number:	NPI:	
Provider email:		Gender: ☐ Female ☐ Male

What type of information are you updating?

Please check all that apply.

☐ Practice details
☐ Primary care provider details
☐ Billing information
☐ New or an additional office location
☐ Remove an office location
☐ Other: _____

Practice details

Office hours:	From:	To:	Age range of patients served:
Monday	_____ a.m.	_____ p.m.	☐ Pediatric ☐ Geriatric
Tuesday	_____ a.m.	_____ p.m.	☐ All ages ☐ Other: _____
Wednesday	_____ a.m.	_____ p.m.	
Thursday	_____ a.m.	_____ p.m.	Languages spoken: _____
Friday	_____ a.m.	_____ p.m.	
Saturday	_____ a.m.	_____ p.m.	Wheelchair accessible? ☐ Yes ☐ No
Sunday	_____ a.m.	_____ p.m.	

Primary care provider details

Primary care providers are **required** to have coverage 24 hours a day, 7 days a week. Please mark your coverage type below.

☐ Answering service ☐ Beeper or pager ☐ Answering machine

☐ Other phone number: _____

Are you accepting new patients? ☐ Yes ☐ No

If no, please explain: _____

BLAPEC-1858-20 December 2020

Billing information
Please attach a copy of the current *W-9* form for all billing information changes.

New tax ID number? ☐ Yes ☐ No	Tax ID number:	
Billing address:		
Contact person:		
City:	State:	Zip:
Phone number:	Fax number:	

New or an additional office location

☐ New location ☐ Additional location

Site name:		
Site address:		
City:	State:	Zip:
Office manager:		
Phone number:	Fax number:	

Office hours:	From:	To:	Age range of patients served:
Monday	_____ a.m.	_____ p.m.	☐ Pediatric ☐ Geriatric
Tuesday	_____ a.m.	_____ p.m.	☐ All ages ☐ Other: _____
Wednesday	_____ a.m.	_____ p.m.	
Thursday	_____ a.m.	_____ p.m.	Languages spoken: _____
Friday	_____ a.m.	_____ p.m.	
Saturday	_____ a.m.	_____ p.m.	Wheelchair accessible? ☐ Yes ☐ No
Sunday	_____ a.m.	_____ p.m.	

Remove an office location

Site name:		
Site address:		
City:	State:	Zip:
Office manager:		
Phone number:	Fax number:	

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

Please sign and date

Signature: _____ Printed name: _____

Contact phone number: _____ Date completed: _____

For office use only

Date received by Healthy Blue: _____