



## Facility, Ancillary Provider and Professional Group Change of Ownership Notification Form

Please complete this form and submit it to BlueCross at least 60 calendar days prior to the date of the anticipated change of ownership or control. You can email the form to [Provider\\_CHOW@BCBST.com](mailto:Provider_CHOW@BCBST.com). Please note that failure to send us the completed form within this time frame may impact your reimbursement rates and claims payments. For more information about the updated Change of Ownership or Control process, please see your Provider Administration Manual and the Change of Ownership or Control FAQs.

### Former Owner (Seller) Information

Legal Business Name: \_\_\_\_\_

"Doing Business As" Name: \_\_\_\_\_

Primary Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer Identification Number (EIN): \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

Taxonomy: \_\_\_\_\_

Is more than one former owner (seller) participating in this CHOW?      Yes      No

If yes, please provide the above information, including all TIN/EIN combinations, for all CHOW participants and submit with this form to BlueCross.

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## New Owner (Buyer) Information

Legal Business Name: \_\_\_\_\_

"Doing Business As" Name: \_\_\_\_\_

Employer Identification Number (EIN): \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

Anticipated Date of Ownership Change: \_\_\_\_\_

Is more than one new owner (buyer) participating in this CHOW?      Yes      No

If yes, please provide the above information, including all TIN/EIN combinations, for all CHOW participants and submit with this form to BlueCross.

## New Owner Contact Information

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

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## Additional Required Documents to Initiate a CHOW

Copy of Buyer's facility or medical license

Universal Credentialing Application/Consolidated Application (to be provided by BlueCross after we receive this form)

IRS Confirmation of Buyer's Tax Identification Number (CP-575 or IRS 147C)

Proposed organization chart for the buyer, including the names and titles of key management staff

Buyer's Medicaid ID (This is required to participate in BlueCare Tennessee networks. To register, please visit [Provider Registration at tn.gov](http://tn.gov))

One of these three applicable documents: purchase agreement, sales agreement OR bill of sale

Amendment to Partnership Agreement *(if applicable)*

LLC Amendment *(if applicable)*

Stock Transfer Agreement *(if applicable)*

Lease Agreement *(if applicable)*

Management Agreement *(if applicable)*

Certificate of Conversion, Articles of Conversion, Statement of Conversion *(if applicable)*

Signed attestation providing assurances that any outstanding compliance issues will be fully resolved

Proof of Electronic Funds Transfer (EFT) enrollment for the buyer

Proof of Electronic Remittance Advice (ERA) enrollment with clearinghouse for the buyer

## Required for Professional Groups Only

Professional roster with name and NPI of practitioners (if new owner assumes existing provider agreement)

Practitioners must enter/update their information in the [CAQH ProView®](#)

Practitioners must enter/update their information in [Change Healthcare's Payment Enrollment Services portal](#)

*Note: Please review the [CHOW FAQ document](#) for steps that must be completed when a new practitioner joins the new owner's group or when a new contract will be issued to the new owner.*

Submitted By: \_\_\_\_\_ Submission Date: \_\_\_\_ / \_\_\_\_ / 20 \_\_\_\_