



An independent licensee of the Blue Cross and Blue Shield Association

CHANGE NOTIFICATION FORM

Certain events may occur that effect your membership status or the way we process your claims. When a change occurs, please complete the information below and return this form to Blue Cross Blue Shield of Wyoming. Our intent is to gather information with this form. It may be necessary to contact you to complete the appropriate paperwork to update your records. **If your healthcare coverage is through your work, please provide this form to your employer.**

If you have questions concerning this form, please call us at 1-800-442-2376.

Please Print Clearly

ID Number:

Effective Date of Change:

NAME CHANGE:

New Last Name

First Name

MI

Previous Last Name

First Name

MI

ADDRESS CHANGE:

Address

Apt/Space/Suite#

City

State

Zip

Telephone Number

For Verification Purposes, please provide your Date of Birth: _____

Signature

Date

**Mail to: Blue Cross Blue Shield of Wyoming
PO Box 2266 ● Cheyenne, WY 82003
Phone 1.800.442.2376 ● Fax 307.634.5742**