



Provider Information Change Form

Instructions: Complete all applicable information. Incomplete submissions may be returned unprocessed. Not for new providers or contractual or credentialing changes. Please submit this form no later than 90 days from the effective date.

Section 1. INDICATE CHANGE(S) BEING SUBMITTED: (Check all that apply):

Effective date: _____

Practice Information (Complete sections 2, 3, 4, 7)

Billing Information (Complete sections 2, 3, 7)

Provider Name (Complete sections 2, 7)

Panel Status (Complete sections 2, 5, 7)

Termination (Complete sections 2, 6, 7)

Indicate documents included: W9-Form Provider Roster Other _____

Section 2. PROVIDER INFORMATION:

Provider Last Name: _____ First Name: _____ MI: _____

Provider Former Name (if applicable): _____

NPI#: PTAN# (if applicable): _____ TAX ID# (W-9 Form Required): _____

Provider Type: PCP Specialist Both Hospitalist only Ancillary/Allied/Mid-Level

IF APPLICABLE, PLEASE ATTACH A SEPARATE LIST WITH THE NAMES AND NPI NUMBERS OF ALL OF THE PROVIDERS IN THIS GROUP FOR WHOM THE ADDRESS CHANGE IS APPLICABLE.

Section 3. UPDATE ADDRESS INFORMATION: Enter New or Additional Addresses Below (If Applicable)

Address type: Primary Secondary Billing Mailing Address

Add Address:

Address line 1: _____ Address line 2: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Remove Address:

Address line 1: _____ Address line 2: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Section 4: PRACTICE INFORMATION: Enter New Information about your Practice

Phone: _____ Fax: _____

Provider Email Address: _____

Staff Language Capabilities: _____

Handicap Access? : _____ Yes _____ No

Office Hours: Mon _____ Tues _____ Weds _____ Thurs _____ Fri _____

Sat _____ Sun _____

Section 5. PRIMARY CARE PANEL STATUS: May be impacted by contract terms and follow-up may be required.

Please check the applicable boxes:

Open panel Close panel Accepting existing patients only

Concierge practice Nursing home only Other (please specify) _____

Section 6. TERMINATION: Effective date may be impacted by contract terms and follow-up may be required.

Reason for termination, please check only one box:

Resigned Retired Deceased Leave of absence* Moved out-of-state Practice closed

Provider sanctioned* Sabbatical* Provider transferred to (group name) Other

*Please provide a separate explanation of the details to the medical group (i.e., duration of absence for leave/sabbatical or sanction specifics).

Section 7. CONTACT PERSON - SUBMITTING INFORMATION:

Name: _____ Title: _____

Phone: _____ Fax: _____

Email: _____ Date of submission: _____

Signature: _____

Note: Please allow 7 – 10 business days for your change to be processed