STANDARDIZED PROVIDER INFORMATION CHANGE FORM

COMPLETE ALL APPLICABLE INFORMATION AND UTILIZE 'SUBMIT' BUTTON BELOW.
INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.
NOT FOR NEW PROVIDERS, CONTRACTUAL MODIFICATIONS, OR CREDENTIALING CHANGES

1. INDICATE CHANGE(S) BEING SUBMITTED: *Check all that apply	***(*Sections 1,2 and 5 are required.)***		
Please include effective date for each item checked.			
☐ Provider Information *(Complete sections 2,3,5)*	Effective Date: _____	☐ Panel Status *(Complete sections 2,4,5)*	Effective Date: _____
☐ Address Information *(Complete sections 2,3,5)*	Effective Date: _____	☐ Group Name *(Complete sections 2,5)*	Effective Date: _____
Indicate documents included: ☐ Provider Roster ☐ Other (List):			

2. PROVIDER INFORMATION: *Section required			
Last Name:	First Name:		Middle Initial:
Provider Former Name *(if applicable)*:			Gender: ☐ Male ☐ Female
Primary Specialty:	IND NPI:		IND TAX ID:
EPSDT (If applicable) : ☐ Yes ☐ No		Accept Medicare & Medicaid: ☐ Yes	☐ No
Hospital Accreditation:			
Hospital Affiliation 1:	2:		3:
Board Certification 1:	2:		3:
Language 1:	2:		3:
Provider Type: ☐ PCP ☐ Ancillary ☐ Behavior Health ☐ Facility ☐ LTSS ☐ Specialist			
Address Line 1:			
Address Line 2:			
City:	State:	County:	Zip Code:
Provider Email Address:			

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.

3. ADDRESS INFORMATION (If adding or changing TIN or Group NPI, please include a copy of the W9.)		
Product: ☐ MA ☐ MMP ☐ Medicaid ☐ All Products		
Group Name:	**Group NPI:**	**Group TAX ID:**
ENTER NEW OR ADDITIONAL ADDRESS BELOW	**ENTER OLD ADDRESSES TO BE TERMINATED BELOW**	
Address Type: ☐ Primary Service ☐ Secondary Service ☐ Correspondence	Address Type: ☐ Primary Service ☐ Secondary Service ☐ Correspondence	
Address Line 1:	Address Line 1:	
Address Line 2:	Address Line 2:	
City:	City:	
State: County: Zip:	State: County: Zip:	
Phone: Fax:	Phone: Fax:	

INFORMATION RELATED TO NEW OR ADDITIONAL SERVICE LOCATION							
Hours of Operation:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open:							
Close:							

Patient Center Medical Home	☐ Yes	☐ No	Location marked and visible from street	☐ Yes	☐ No
Location easily accessible via public transportation	☐ Yes	☐ No	Accessible to members with disabilities	☐ Yes	☐ No
Designated parking for disabled	☐ Yes	☐ No	Restrooms accessible for people with disabilities	☐ Yes	☐ No
Wheelchair ramps	☐ Yes	☐ No	Auto-open external doors	☐ Yes	☐ No
Waiting room accommodate patients in wheelchairs/scooters	☐ Yes	☐ No	Exam rooms with accessible equipment	☐ Yes	☐ No
If radiology offered, accessible to disabled patients	☐ Yes	☐ No	ADA compliance on service animals	☐ Yes	☐ No
Materials available in braille and large print	☐ Yes	☐ No	ASL interpretation available	☐ Yes	☐ No

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

☐Open panel ☐Close panel ☐Nursing home only ☐Accepting existing patients only ☐Other *(please specify):* _____

5. CONTACT PERSON SUBMITTING INFORMATION:** ****Section required.

Name:	Title:
Phone:	Fax:
Email:	Date of Submission:

SUBMIT FORM **RESET FORM**