



# 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Primary Specialty:		IND NPI:		IND TAX ID:	
EPSDT (If applicable) : <input type="checkbox"/> Yes <input type="checkbox"/> No				Accept Medicare & Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospital Accreditation:					
Hospital Affiliation 1:		2:		3:	
Board Certification 1:		2:		3:	
Language 1:		2:		3:	
Provider Type: <input type="checkbox"/> PCP <input type="checkbox"/> Ancillary <input type="checkbox"/> Behavior Health <input type="checkbox"/> Facility <input type="checkbox"/> LTSS <input type="checkbox"/> 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: <input type="checkbox"/> Primary Service <input type="checkbox"/> Secondary Service <input type="checkbox"/> Correspondence			Address Type: <input type="checkbox"/> Primary Service <input type="checkbox"/> Secondary Service <input type="checkbox"/> Correspondence		
Address Line 1:			Address Line 1:		
Address Line 2:			Address Line 2:		
City:			City:		
State:		County:		Zip:	
Phone:		Fax:		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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location marked and visible from street		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Location easily accessible via public transportation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Accessible to members with disabilities		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Designated parking for disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No	Restrooms accessible for people with disabilities		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Wheelchair ramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Auto-open external doors		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Waiting room accommodate patients in wheelchairs/scooters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Exam rooms with accessible equipment		<input type="checkbox"/> Yes <input type="checkbox"/> No			
If radiology offered, accessible to disabled patients	<input type="checkbox"/> Yes <input type="checkbox"/> No	ADA compliance on service animals		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Materials available in braille and large print	<input type="checkbox"/> Yes <input type="checkbox"/> No	ASL interpretation available		<input type="checkbox"/> Yes <input type="checkbox"/> No			



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### 3. ADDRESS INFORMATION (If adding or changing TIN or Group NPI, please include a copy of the W9.)

Product: <input type="checkbox"/> MA <input type="checkbox"/> MMP <input type="checkbox"/> Medicaid <input type="checkbox"/> All Products		
Group Name:	Group NPI:	Group TAX ID:
<b>ENTER NEW OR ADDITIONAL ADDRESS BELOW</b>		<b>ENTER OLD ADDRESSES TO BE TERMINATED BELOW</b>
Address Type: <input type="checkbox"/> Primary Service <input type="checkbox"/> Secondary Service <input type="checkbox"/> Correspondence		Address Type: <input type="checkbox"/> Primary Service <input type="checkbox"/> Secondary Service <input type="checkbox"/> Correspondence
Address Line 1:		Address Line 1:
Address Line 2:		Address Line 2:
City:		City:
State:	County:	Zip:
Phone:	Fax:	Zip:

### INFORMATION RELATED TO NEW OR ADDITIONAL SERVICE LOCATION

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Waiting room accommodate patients in wheelchairs/scooters	<input type="checkbox"/> Yes <input type="checkbox"/> No		Exam rooms with accessible equipment		<input type="checkbox"/> Yes <input type="checkbox"/> No		
If radiology offered, accessible to disabled patients	<input type="checkbox"/> Yes <input type="checkbox"/> No		ADA compliance on service animals		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Materials available in braille and large print	<input type="checkbox"/> Yes <input type="checkbox"/> No		ASL interpretation available		<input type="checkbox"/> Yes <input type="checkbox"/> No		

### 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: