

STANDARDIZED PROVIDER INFORMATION CHANGE FORM

COMPLETE ALL <u>APPLICABLE</u> 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 app	ly (*Sections 1,2 and 5 are required.)	
Please include effective date for each item che	cked.		
□ 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:	ler Roster 🛛 🗌	Other (List):	

*2. PROVIDER INFORMATION: *Section required					
Last Name:	First Name:		Middle Initial:		
Provider Former Name (if applicable):			Gender: 🗆 Ma	ale 🗆 Female	
Primary Specialty:	IND NPI:		IND TAX ID:		
EPSDT (If applicable) :		Accept Medi	care & Medicaid:	🗆 Yes	□No
Hospital Accreditation:					
Hospital Affiliation 1:	2:		3:		
Board Certification 1:	2:		3:		
Language 1:	2:		3:		
Provider Type: PCP Ancillary	\Box Behavior Health	□ Facility			st
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 Med	licaid 🗌 All P	roducts						
Group Name:				Group NPI: Group TAX ID:				
ENTER NEW OR ADDITIONAL	ADDRESS BELO	w		ENTER OLD	ADDRESSES TO	BE TERMINATED	BELOW	
Address Type: Primary Service	Secondary Ser	vice	Addre	ess Type: 🗆 Pi	rimary Service	□ Secondary	Service	
□ Correspondence				orresponder	ice			
Address Line 1:			Addre	ess Line 1:				
Address Line 2:			Addre	ess Line 2:				
City:			City:					
State: County:	Zip:		State:		County:	Zip):	
Phone: Fax:			Phone: Fax:					
INFORMATION RELATED TO NEW OF				DITIONAL SEF	VICE LOCATION			
Hours of Operation: Monday	Tuesday	Wednesday	/	Thursday	Friday	Saturday	Sund	day
Open:								
Close:								
Patient Center Medical Home		□Yes	□No	Location ma	rked and visible from	om street	□Yes	□No
Location easily accessible via public transpo	rtation	□Yes	□No	Accessible to	o members with di	sabilities	□Yes	□No
Designated parking for disabled		□Yes	□No	Restrooms a	ccessible for peop	le with disabilities	□Yes	□No
Wheelchair ramps		□Yes	□No	Auto-open e	external doors		□Yes	□No
Waiting room accommodate patients in whe	eelchairs/scooters	s □Yes	□No	Exam rooms	with accessible ed	quipment	□Yes	□No
If radiology offered, accessible to disabled patients			□No	ADA compliance on service animals			□No	
Materials available in braille and large print		□Yes	□No	ASL interpre	tation available		□Yes	□No



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Product: MA MMP Medicaid All Products Group Name: Group TAX ID: Group TAX ID: ENTER NEW OR ADDITIONAL ADDRESS BELOW Address Type: Primary Service Secondary Service Address Type: Primary Service Secondary Service Address Type: Primary Service Secondary Service Address Line 1: County: Zip: State: County: <th< th=""><th colspan="5">3. ADDRESS INFORMATION (If adding or changing TIN or Group NPI, please include a copy of the W9.)</th></th<>	3. ADDRESS INFORMATION (If adding or changing TIN or Group NPI, please include a copy of the W9.)									
ENTER NEW OR ADDITIONAL ADDRESS BELOW Address Type: Primary Service Secondary Service Address Type: Primary Service Secondary Service Correspondence Address Type: Primary Service Secondary Service Correspondence Address Type: Primary Service Secondary Service Address Line 1: Address Line 1: Address Line 1: Address Line 2: Correspondence Correspondence Address Line 2: County: Zip: City: City: Zip: Verset State: County: Tax: Yes: Fax: Zip: Verset Phone: Fax: Phone: Fax: Friday Saturday Sunday Hours of Operation: Monday Tuesday Wednesday Friday Saturday Sunday Close: Image: Sible Via public transportation Yes No Accessible to members with disabilities Yes No Designated parking for disabled Yes No Accessible to members with disabilities Yes No Mine construct for disabled patients in wheelchairs/scooters Yes No Accessible cons avit	Product: 🗆 MA 🗌 MMP 🔲 Medicaid 🔲 All Products									
Address Type: Primary Service Secondary Service Address Type: Primary Service Secondary Service Address Line 1: Address Line 1: Address Line 1: Address Line 2: Address Line 2: Address Line 2: Secondary Service Secondary Service City: State: County: Zip: State:	Group Name:				Grou	p NPI:		Group TAX ID:		
□ Correspondence □ Correspondence Address Line 1: Address Line 1: Address Line 2: Address Line 2: City: City: State: County: Fax: Phone: <	ENTER NEV	V OR ADDITION	AL ADDRESS BELO	w		ENTER OLI	D ADDRESSES TO	BE TERMINATED	BELOW	
Address Line 1: Address Line 1: Address Line 2: Address Line 2: Address Line 2: City: State: County: Zip: Zip: Yint Zip: Yint			Secondary Ser	vice	Addre	ess Type: 🗆 P	rimary Service	Secondary	Service	
Address Line 2: Address Line 2: City: City: State: County: Zip: Fax: Phone: Fax: INFORMATION RELATED TO NEW OF ADDITIONAL SERVICE LOCATION Hours of Operation: Monday Tuesday Wednesday Thursday Friday Saturday Sunday Open: Monday Tuesday Vednesday Thursday Friday Saturday Sunday 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 Wheelchair ramps Yes No Auto-open external doors Yes No Waiting room accommodate patients in wheelchairs/scooters Yes No ADA compliance on service animals Yes No If radiology offered, accessible to disabled patients Yes No ADA compliance on service animals Yes No	☐ Correspondence	2				orresponder	nce			
City: City: State: County: Zip: State: County: Zip: Phone: Fax: Phone: Fax: Fax: Fax: INFORMATION RELATED TO NEW OF ADDITIONAL SERVICE LOCATION Hours of Operation: Monday Tuesday Wednesday Thursday Friday Saturday Sunday Open: One Image: County: Saturday Sunday Sunday Sunday Patient Center Medical Home Yes No Location marked and visible from street Yes No Location easily accessible via public transportation 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 Auto-open service animals Yes No If radiology offered, accessible to disabled patients Yes No ADA compliance on service animals Yes No	Address Line 1:				Addre	ess Line 1:				
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INFORMATION RELATED TO NEW OR ADDITIONAL SERVICE LOCATION Hours of Operation: Monday Tuesday Wednesday Thursday Friday Saturday Sunday Open: Image: I	State: Co	unty:	Zip:		State:		County:	Zip	:	
Hours of Operation: Monday Tuesday Wednesday Thursday Friday Saturday Sunday Open: Image: Close: Image: Cl	Phone: Fax:				Phone: Fax:			Fax:		
Open:		INFC	RMATION RELAT	ED TO NEW C	OR ADD	DITIONAL SER	RVICE LOCATION			
Close: Image: Close:	Hours of Operation:	Monday	Tuesday	Wednesday		Thursday	Friday	Saturday	Sund	day
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	Open:									
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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	Location easily accessib	ole via public transp	portation	□Yes	□No	Accessible t	o members with di	sabilities	□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	Designated parking for	disabled		□Yes	□No	Restrooms a	accessible for peop	le with disabilities	□Yes	□No
If radiology offered, accessible to disabled patients \Box Yes \Box No ADA compliance on service animals \Box Yes \Box No	Wheelchair ramps			□Yes	□No	Auto-open external doors			□Yes	□No
	Waiting room accommodate patients in wheelchairs/scooters			s 🗌 Yes	□No	Exam rooms with accessible equipment			□Yes	□No
Materials available in braille and large print \Box Yes \Box No ASL interpretation available \Box Yes \Box 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	o ASL interpretation available			□Yes	□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 (*pleasespecify*): _

*5. CONTACT PERSON SUBMITTING INFORMATION: *Section required.				
Name:	Title:			
Phone:	Fax:			
Email:	Date of Submission:			

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