

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 apply	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:
\Box Address Information (<i>Complete sections 2,3,5</i>)	Effective Date:	Group Name (Complete sections 2,5)	Effective Date:
Indicate documents included: 🛛 🖓 Provid	ler Roster 🛛 🗌	Other (List):	

*2. PROVIDER INFORMATION: *Section required					
Last Name:	First Name:		Middle Initial:		
Provider Former Name (if applicable):			Gender: 🗆 Ma	ale 🗆 Fema	ile
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:	□ Behavior Health	□ Facility		🗆 Speci	alist
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 L	⊥ MMP ⊔ Me	edicaid 🛛 All F	Products						
Group Name:				Grou	Group NPI: Group TAX ID:				
ENTER NEV	N OR ADDITIONA	AL ADDRESS BELC	w		ENTER OLD	ADDRESSES TO	BE TERMINATED	BELOW	
Address Type: 🗆 Prim	ary Service	Secondary Se	rvice	Addre	ss Type: 🗆 P	rimary Service	Secondary	Service	
					prresponder	ice			
					ss Line 1:				
Address Line 2:				Addre	ss Line 2:				
City:				City:					
State: Co	unty:	Zip:		State:	te: County: Zip):	
Phone: Fax:				Phone	Phone: Fax:				
INFORMATION RELATED TO NEW					ITIONAL 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 accessib	ole via public transp	ortation	□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			□No	Auto-open external doors			□No		
Waiting room accommodate patients in wheelchairs/scooters			□No	Exam rooms with accessible equipment			□No		
If radiology offered, accessible to disabled patients				□No	ADA compliance on service animals			□No	
Materials available in braille and large print				□No	ASL interpretation available			□No	



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Product: MA MAP Medicaid All Products Group Name: Group N2 Group ALD ENTER NEW OR ADDITIONAL ADDRESS BLOW Address Type: Primary Service Secondary Service	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 Address Type: Primary Service Secondary Service Address Line 1: Address Line 1: Address Line 1: Address Line 1: Address Line 2: City: State: County: Zip: Zip: Veloation: Zip: Veloation: Zip: Veloation: Zip: Veloation: Zip: Veloation: Zip: Veloation: Veloation: Veloation: Saturday Sundary Nopen: Monday Tuesday Welensday Tursday Friday Saturday Sundary Open: Monday Tuesday Welensday Tursday Friday Saturday Sundary Patient Center Medical Home	Product: 🗆 MA 🗆 MMP 🔲 Medicaid 🔲 All Products									
Address Type: Primary Service Address Type: Primary Service Secondary Service Correspondence Correspondence Address Line 1: Address Line 1: Address Line 2: City: Secondary Service Secondary Service Secondary Service Address Line 2: Address Line 2: Address Line 2: City: State: County: Zip: State: County: City: County	Group Name:				Group	NPI:		Group TAX ID:		
□ Correspondence □ Correspondence Address Line 1: Address Line 1: Address Line 2: Address Line 2: City: City: State: County: Zip: State: Phone: Fax: <	ENTER NEV	VOR ADDITION	AL ADDRESS BELO	W		ENTER OLD	ADDRESSES TO	BE TERMINATED	BELOW	
Address Line 1: Address Line 2: Address Line 2: Address Line 2: City: State: County: Zip: View County: View County: Zip: View County: Zip: View County: Zip: View County: Zip: ViewCounty:			Secondary Ser	vice	Address Type: Primary Service Secondary Service					
Address Line 2:Address Line 2:City:City:State:County:Zip:State:Phone:Fax:Phone:Fax:INFORMATION RELATED TO NEW OR MESdayThursdayFridaySaturdaySundayOpen:MondayTuesdayWednesdayThursdayFridaySaturdaySundayOpen:MondayTuesdayWednesdayThursdayFridaySaturdaySundayClose:Image: Colspan="4">Image: Colspan="4">Open:Patient Center Medical HomeYesNoLocation marked and visible from streetYesNoLocation easily accessible via public transportationYesNoAccessible to members with disabilitiesYesNoDesignated parking for disabledYesNoAuto-open external doorsYesNoWaiting room accommodate patients in wheelchairs/scootersYesNoExam rooms with accessible equipmentYesNo	Correspondence	2			□ Co	rresponder	ice			
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: Image: County: Monday Tuesday Yes Image: County: Image: C	Address Line 1:				Addre	ss Line 1:				
State: County: Zip: State: County: Zip: Phone: Fax: Phone: Fax: Fa	Address Line 2:				Addre	ss Line 2:				
Phone: Fax: Phone: Fax: INFORMATION RELATED TO NEW OR ADDITIONAL SERVICE LOCATION Hours of Operation: Monday Tuesday Wednesday Thursday Friday Saturday Sunday Open: Image: Colspan="4">Image: Colspan="4">Colspan= Colspan="4">Colspan= Colspan=	City:				City:					
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Materials available in braille and large print Image: Pressing and Pressing available Image: Pressing available Image: Pressing available Image: Pressing available	Materials available in b	raille and large pri	nt	□Yes	□No	ASL interpre	tation 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:			