

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.			
<input type="checkbox"/> Provider Information (Complete sections 2,3,5)	Effective Date: _____	<input type="checkbox"/> Panel Status (Complete sections 2,4,5)	Effective Date: _____
<input type="checkbox"/> Address Information (Complete sections 2,3,5)	Effective Date: _____	<input type="checkbox"/> Group Name (Complete sections 2,5)	Effective Date: _____
Indicate documents included: <input type="checkbox"/> Provider Roster <input type="checkbox"/> Other (List): _____			

*2. PROVIDER INFORMATION: *Section required			
Last Name:		First Name:	
Provider Former Name (if applicable):		Middle Initial:	
Primary Specialty:		IND NPI:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		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:
Provider Email Address:		Zip Code:	

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: <input type="checkbox"/> MA <input type="checkbox"/> MMP <input type="checkbox"/> Medicaid <input type="checkbox"/> 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:	State:	County:
Phone:	Fax:	Phone:	Fax:
Zip:	Zip:	Zip:	Zip:

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

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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

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		

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: