

Provider Update Information Data Sheet

All fields with Asterix are mandatory. Please complete this form in its entirety and use "N/A" if not applicable.*

Provider Information		
*Group Name / Facility Name / Legal Name:		*Group Tax ID:
*Last Name:	*First Name:	*Provider's NPI:
<input type="checkbox"/> Service Location Add: <i>If more than one office, please attach roster of all locations. (Address, phone, fax, LOBs)</i>		
Address: Phone: Fax:	Applicable lines of business: <input type="checkbox"/> Medicaid <input type="checkbox"/> Marketplace <input type="checkbox"/> Duals <input type="checkbox"/> Medicare <input type="checkbox"/> CHP	Does this provider perform PCP duties at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this location a FQHC? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Service Location Term:		
Address:		Term Date:
Does this require a member move? <input type="checkbox"/> No <input type="checkbox"/> Yes (please fill out box to the right)		<input type="checkbox"/> Members staying with same provider at other active location: <input type="checkbox"/> Members to be moved to another provider: Provider Name: Provider NPI: Address: *Please include terming provider approval to move members to an alternative provider
<input type="checkbox"/> Age Restriction Update:		
Age Restriction: From: _____ To: _____		Does this apply to all locations? <input type="checkbox"/> Yes <input type="checkbox"/> No. Please specify which location(s):

Does this require a member move? <input type="checkbox"/> No <input type="checkbox"/> Yes (please fill out box to the right)	Members outside of age restriction to be moved to another provider: Provider Name: Provider NPI: Address:	
<input type="checkbox"/> Open / Close Panels:		
<input type="checkbox"/> Open Panels <input type="checkbox"/> Close Panels	Does this apply to all locations? <input type="checkbox"/> Yes <input type="checkbox"/> No. Please specify which location(s):	Applicable lines of business: <input type="checkbox"/> Medicaid <input type="checkbox"/> Marketplace <input type="checkbox"/> Duals <input type="checkbox"/> Medicare <input type="checkbox"/> CHP
<input type="checkbox"/> Specialty Change		
Add Specialty (description and taxonomy): Remove Specialty:		
<input type="checkbox"/> Phone or Fax Number Update:		
Address: Phone: Fax:		
<input type="checkbox"/> Supervising Physician Update:		
Remove Supervising Physician: Name: NPI: Add Supervising physician: Name: NPI:		
<input type="checkbox"/> Other, please be as detailed as possible:		