STANDARDIZED PROVIDER INFORMATION CHANGE FORM

COMPLETE ALL APPLICABLE INFORMATION. INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.
NOT FOR NEW PROVIDERS OR CONTRACTUAL OR CREDENTIALING CHANGES.

1. INDICATE CHANGE(S) BEING SUBMITTED:** ***(Check all that apply — please include effective date for each item checked.)
****Section required.***

	Effective date		***Effective date***
☐ Practice information *(Complete sections 2, 3, 6)*	_____	☐ Practice status *(Complete sections 2, 4, 6)*	_____
☐ Billing information *(Complete sections 2, 3, 6)*	_____	☐ Termination *(Complete sections 2, 5, 6)*	_____
☐ Provider name *(Complete sections 2, 6)*	_____		

Indicate documents included: ☐ W9 ☐ Provider Roster ☐ Other _____

PLEASE COMPLETE THE APPLICABLE SECTIONS BELOW TO UPDATE YOUR INFORMATION.
IF CHANGING TAX INFORMATION, YOU ARE REQUIRED TO SUBMIT AN UPDATED W9 WITH THIS FORM.

2. PROVIDER INFORMATION:** ****Section required.

Provider Last Name:	First Name:	MI:	Credential:
Provider Former Name *(if applicable)*:			
NPI#:	Medicaid ID# *(if applicable)*:	PTAN# *(if applicable)*:	TAX ID#:	Gender:
Provider Type: ☐ PCP ☐ Specialist ☐ Both ☐ Hospitalist only ☐ Ancillary/Allied/Mid-Level ☐ Behavioral Health Provider ☐ Moonlighting/Covering			
Practice/Business name:			
Institutional Affiliation:			
Street:			
City:	State:	Zip:	
Phone:	Fax:		
Provider Email Address:	Provider Website:		
Board Certification 1:	Board Certification 2:		

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:

ENTER NEW OR ADDITIONAL ADDRESSES BELOW		**ENTER DATA THAT IS NO LONGER APPLICABLE**	
Address type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing		Address type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing	
Address line 1:	Suite #:	Address line 1:	Suite #:
Address line 2:	Suite #:	Address line 2:	Suite #:
City:		City:	
State:	Zip:	State:	Zip:
Phone:	Fax:	Phone:	Fax:
☐ Suppress Address		☐ Suppress Address	
Office Hours:	Disability Access: ☐ Yes ☐ No	Office Hours:	Disability Access: ☐ Yes ☐ No
Languages Spoken by Provider or Office Staff:		Languages Spoken by Provider or Office Staff:	

Address type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing		Address type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing	
Address line 1:		Address line 1:	
Address line 2:		Address line 2:	
City:		City:	
State:	Zip:	State:	Zip:
Phone:	Fax:	Phone:	Fax:
Office Hours:	Disability Access: ☐ Yes ☐ No	Office Hours:	Disability Access: ☐ Yes ☐ No
Languages Spoken by Provider or Office Staff:		Languages Spoken by Provider or Office Staff:	

Contact person completing form: _____ Phone: _____

(continued on next page)

STANDARDIZED PROVIDER INFORMATION CHANGE FORM (*CONTINUED*)

Provider Name: _____

4. PRACTICE STATUS: *May be impacted by contract terms and follow-up may be required.*

Practitioner availability status:

- ☐ Accepting new patients
- ☐ Accepting existing patients only
- ☐ Closed *(not accepting new patients and not accepting existing patients)*
- ☐ Concierge practice
- ☐ Skilled nursing facilities
- ☐ Other *(please specify)* _____

Do you offer telemedicine/telehealth (i.e., video visits)? ☐ Yes ☐ No

Do you offer lactation counseling services? ☐ Yes ☐ No

5. TERMINATION: *Effective date may be impacted by contract terms and follow-up may be required.*

Reason for termination, please check only one box:

- ☐ Resigned
- ☐ Retired
- ☐ Deceased
- ☐ Leave of absence*
- ☐ Moved out-of-state
- ☐ Practice closed
- ☐ Provider sanctioned*
- ☐ Sabbatical*
- ☐ Provider transferred to *(group name)* _____
- ☐ Other _____

**Please provide a separate explanation of the details to the plan (i.e., duration of absence for leave/sabbatical or sanction specifics).*

*6. CONTACT PERSON SUBMITTING INFORMATION: **Section required.*

Name:	Title:
Phone:	Fax:
Email:	
Date of submission:	

7. CLASSIFICATIONS/MODALITIES/POPULATIONS SERVED

For behavioral health providers; please indicate your classifications, modalities, and populations served.

Classifications/Areas of Practice		Modalities/Treatment Methods	Ages
☐ ACOA/codependence	☐ Immigrant/refugee issues	☐ Ambulatory detox	☐ Children under age 6
☐ Adoptee	☐ Infertility	☐ Applied behavioral analysis	☐ Children ages 6–12
☐ Adopting parents	☐ Internet addictions	☐ Behavioral therapy	☐ Adolescents 13–18
☐ AIDS/HIV	☐ Medical illness/diagnosis MGMT	☐ CBT	☐ Adults 18–64
☐ Anger issues	☐ Military/veterans issues	☐ Couples therapy	☐ Geriatric 65+
☐ Anxiety disorders	☐ Multicultural issues	☐ Dialectical behavioral therapy	**Population(s) Served**
☐ Attention deficit/hyperactivity disorder	☐ Obsessive-compulsive disorders	☐ ECT	☐ Disabled
☐ Autism spectrum disorders	☐ Opioid use disorders	☐ EMDR	☐ First Responders
☐ Bariatric counseling/obesity	☐ Panic/phobias	☐ Faith-based counseling	☐ Health care population
☐ Bipolar disorder	☐ Personality disorders	☐ Family therapy	☐ Hearing impairment
☐ Chronic mental disorders	☐ Physical abuse	☐ Group therapy	☐ Homebound
☐ Chronic pain	☐ Pregnancy/postpartum/loss	☐ Hypnotherapy	☐ LGBTQ
☐ Conduct/oppositional defiant disorders	☐ Psychotic disorders	☐ MAT for substance use disorders	☐ Nursing home patients
☐ Depressive disorders	☐ PTSD	☐ Neuropsych assessment	☐ Refugees/immigrants
☐ Developmental disabilities	☐ Sexual abuse	☐ Pain management services	☐ Veterans, military
☐ Disability management	☐ Sexual addictions	☐ Play therapy	☐ Visual impairment
☐ Domestic violence	☐ Sexual dysfunction	☐ Psychological assessment	
☐ Dual diagnosis	☐ Sleep disorders	☐ Suboxone/Buprenorphine prescribing	
☐ Eating disorders	☐ Substance use disorders	☐ Transcranial magnetic stimulation	
☐ First responder issues	☐ Trauma		
☐ Gambling addictions			
☐ Gender identity/sexuality issues			
☐ Grief counseling			