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

☐Open / Close Panels:

☐Open Panels ☐Close Panels	Does this apply to all locations? ☐Yes ☐No. Please specify which location(s):	Applicable lines of business: ☐Medicaid ☐Marketplace ☐Duals ☐Medicare ☐CHP

☐Specialty Change

Add Specialty (description and taxonomy):

Remove Specialty:

☐Phone or Fax Number Update:

Address:

Phone:
Fax:

☐Supervising Physician Update:

Remove Supervising Physician:
Name:
NPI:
Add Supervising physician:
Name:
NPI:

☐Other, please be as detailed as possible: