STANDARDIZED PROVIDER INFORMATION CHANGE FORM

COMPLETE ALL APPLICABLE INFORMATION. INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.

NOT TO BE USED 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, 7)*	_____	☐ 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.
NOT TO BE USED FOR NEW PROVIDERS OR CONTRACTUAL OR CREDENTIALING CHANGES.

2. PROVIDER INFORMATION:** ****Section required.				
Provider Last Name:	First Name:	MI:	Credential:	
Provider Former Name *(if applicable)*:				
NPI#:	Medicaid ID#:	PTAN#:	TAX ID#:	Gender:
Provider Type: ☐ Substance Use Provider ☐ PCP ☐ Specialist ☐ Hospitalist only ☐ Ancillary/Allied/Mid-Level ☐ Behavioral Health Provider ☐ Moonlighting/Covering				
Practice/Business name:				
Street:				
City:	State:	Zip:		
Phone:	Fax:			
Provider Email Address:	Provider Website:			
Languages Spoken by Provider or Clinical Staff:				
Board Certification 1:	Board Certification 2:			
Institutional Affiliation:				

IF APPLICABLE, PLEASE ATTACH A SEPARATE LIST WITH THE NAMES AND NPI NUMBERS OF ALL OF THE PROVIDERS IN THIS GROUP TO WHOM THE ADDRESS CHANGE APPLIES.

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ENTER NEW OR ADDITIONAL ADDRESSES BELOW		**ENTER DATA THAT IS NO LONGER APPLICABLE**	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:		Address line 2:	
City:		City:	
State:	Zip:	State:	Zip:
☐ Suppress Address		☐ Suppress Address	
Phone:	Fax:	Phone:	Fax:
TAX ID#:		TAX ID#:	
Office Hours:	Disability Access: ☐ Yes ☐ No	Office Hours:	Disability Access: ☐ Yes ☐ No
Languages Spoken by Office Staff:		Languages Spoken by Office Staff:	
Can a patient call and make an appointment for this provider at this location? ☐ Yes ☐ No			

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STANDARDIZED PROVIDER INFORMATION CHANGE FORM (*CONTINUED*)

Provider Name: ______________________________

3. ADDRESS INFORMATION (*continued*):

ENTER NEW OR ADDITIONAL ADDRESSES BELOW		ENTER DATA THAT IS NO LONGER APPLICABLE	
Address type: ☐ Primary ☐ Billing	☐ Secondary ☐ Mailing	Address type: ☐ Primary ☐ Billing	☐ Secondary ☐ Mailing
Address line 1:	Suite #:	Address line 1:	Suite #:
Address line 2:		Address line 2:	
City:		City:	
State:	Zip:	State:	Zip:
☐ Suppress Address		☐ Suppress Address	
Phone:	Fax:	Phone:	Fax:
TAX ID#:		TAX ID#:	
Office Hours:	Disability Access: ☐ Yes ☐ No	Office Hours:	Disability Access: ☐ Yes ☐ No
Languages Spoken by Office Staff:		Languages Spoken by Office Staff:	
Can a patient call and make an appointment for this provider at this location? ☐ Yes ☐ No			

ENTER NEW OR ADDITIONAL ADDRESSES BELOW		ENTER DATA THAT IS NO LONGER APPLICABLE	
Address type: ☐ Primary ☐ Billing	☐ Secondary ☐ Mailing	Address type: ☐ Primary ☐ Billing	☐ Secondary ☐ Mailing
Address line 1:	Suite #:	Address line 1:	Suite #:
Address line 2:		Address line 2:	
City:		City:	
State:	Zip:	State:	Zip:
☐ Suppress Address		☐ Suppress Address	
Phone:	Fax:	Phone:	Fax:
TAX ID#:		TAX ID#:	
Office Hours:	Disability Access: ☐ Yes ☐ No	Office Hours:	Disability Access: ☐ Yes ☐ No
Languages Spoken by Office Staff:		Languages Spoken by Office Staff:	
Can a patient call and make an appointment for this provider at this location? ☐ Yes ☐ No			

ENTER NEW OR ADDITIONAL ADDRESSES BELOW		ENTER DATA THAT IS NO LONGER APPLICABLE	
Address type: ☐ Primary ☐ Billing	☐ Secondary ☐ Mailing	Address type: ☐ Primary ☐ Billing	☐ Secondary ☐ Mailing
Address line 1:	Suite #:	Address line 1:	Suite #:
Address line 2:		Address line 2:	
City:		City:	
State:	Zip:	State:	Zip:
☐ Suppress Address		☐ Suppress Address	
Phone:	Fax:	Phone:	Fax:
TAX ID#:		TAX ID#:	
Office Hours:	Disability Access: ☐ Yes ☐ No	Office Hours:	Disability Access: ☐ Yes ☐ No
Languages Spoken by Office Staff:		Languages Spoken by Office Staff:	
Can a patient call and make an appointment for this provider at this location? ☐ Yes ☐ No			

Contact person completing form: ______________________________ Phone: ______________________

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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. BEHAVIORAL HEALTH PROVIDERS:

Please indicate your areas of practice, treatment methods, and ages and populations served.

Areas of Practice		Modalities/Treatment Methods	Ages Treated
☐ 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 impaired
☐ 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	☐ Visually impaired
☐ 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			