

Provider Change Form

About the change					
Please provide a brief explanation of the change					
Physician name					
Group / facility name					
Current Tax ID		NPI number		Today's date	

Person completing this form	
Name	
Phone	
E-mail	

Type of change			
<input type="checkbox"/> Leaving a participating provider group or Priority Health Network Priority Health requires written notice, 90 days in advance. Physicians or groups who choose to leave the Priority Health network will not be allowed to re-contract with the plan for 12 months, or until the next contract year, whichever is longer. Please visit <i>Office Management and Standards</i> in the Provider Manual at priorityhealth.com for more information.			Effective date _____
Networks leaving:	<input type="checkbox"/> HMO/POS <input type="checkbox"/> EPO/POS	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> All products
Reason for leaving:	<input type="checkbox"/> Deceased <input type="checkbox"/> Retiring <input type="checkbox"/> Leave of absence <input type="checkbox"/> Moving outside the service area <input type="checkbox"/> Moving to another participating group		<input type="checkbox"/> Patients moving with physician <input type="checkbox"/> Patients staying at current practice (complete transfer info.) <input type="checkbox"/> Termining contract <input type="checkbox"/> Other _____
Extension of Care (EOC):	<input type="checkbox"/> Yes <input type="checkbox"/> No EOC, members remain with group		<input type="checkbox"/> No EOC, still in network <input type="checkbox"/> EOC refused
Physician agrees to transfer his/her members to:	<input type="checkbox"/> One PCP	Physician name	
	<input type="checkbox"/> Multiple PCPs	Physician name	
		Physician name	
		Physician name	
How do you want your members divided among multiple PCPs? (Choose One)	<input type="checkbox"/> Age <input type="checkbox"/> Gender <input type="checkbox"/> Zip code	Please specify:	

Extension of care information is available in our online provider manual. Go to priorityhealth.com/provider and select manual. Go to "Office Management & Standards" and then "Patient status."

<input type="checkbox"/> PCP changing to specialist (SCP)	Effective date	
Will you be doing home visits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you a hospitalists (in the hospital 100% of your time)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will you have a private practice location?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<input type="checkbox"/> Demographic (address, phone or fax) change		Effective date	
Name "on the door" of this location			
<input type="checkbox"/> Add	Term date (last day) old address is valid		
<input type="checkbox"/> Delete	Effective date new address is valid on		
Address type (check all that apply)	<input type="checkbox"/> Primary	<input type="checkbox"/> Billing/remit	<input type="checkbox"/> Other
	<input type="checkbox"/> Secondary	<input type="checkbox"/> Tax ID address*	<input type="checkbox"/> All
Address			
City		State	ZIP
Phone		Fax	
Practice/ facility hours	Monday	Tuesday	Wednesday
	Thursday	Friday	Saturday
	Sunday		
Open			
Close			
Do you want the new address listed in our online provider directory (Find a Doctor)?			<input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> Demographic (address, phone or fax) change		Effective date	
Name "on the door" of this location			
<input type="checkbox"/> Add	Term date (last day) old address is valid		
<input type="checkbox"/> Delete	Effective date new address is valid on		
Address type (check all that apply)	<input type="checkbox"/> Primary	<input type="checkbox"/> Billing/remit	<input type="checkbox"/> Other
	<input type="checkbox"/> Secondary	<input type="checkbox"/> Tax ID address*	<input type="checkbox"/> All
Address			
City		State	ZIP
Phone		Fax	
Practice/ facility hours	Monday	Tuesday	Wednesday
	Thursday	Friday	Saturday
	Sunday		
Open			
Close			
Do you want the new address listed in our online provider directory (Find a Doctor)?			<input type="checkbox"/> Yes <input type="checkbox"/> No

*You must include a W-9 for this change. **Note:** There should not be a gap between the term and effective date of this change. If this also changes the EDI Receipt fax number, where electronic claim receipt notices are sent, please notify EDI at 800 942-0954 ext. 48686 or EDISETUP@priorityhealth.com.

<input type="checkbox"/> Name, Tax ID* or NPI Change			Effective date	
Current name		New name		
Old dates of service will be billed with:		<input type="checkbox"/> Old name <input type="checkbox"/> New name		
Current Tax ID		New Tax ID*		
Current NPI		New NPI		

***You must include a W-9 for this change.**

<input type="checkbox"/> Age panel limit change				Effective date	
New age panel	<input type="checkbox"/> Family Practice (1 day to 99+ years)	<input type="checkbox"/> General Practice (1 day to 99+ years)	<input type="checkbox"/> Gynecology (13 to 99+ years)	<input type="checkbox"/> Internal Medicine (16 to 99+ years)	
	<input type="checkbox"/> IM/Pediatrics (1 day to 99+ years)	<input type="checkbox"/> OB/Gyn (13 to 99+ years)	<input type="checkbox"/> Pediatrics (1 day to 18 years)	<input type="checkbox"/> Other	
	If other, age panel requesting:				

Note: If a practitioner has members outside the new limits, member may be transferred to another practitioner.

<input type="checkbox"/> Open/close status change				Effective date	
Priority Health must receive changes 60 days prior to their effective date or claims may be denied (unless otherwise noted).					
Opening to	<input type="checkbox"/> HMO/POS	<input type="checkbox"/> EPO/POS	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	
Closing to	<input type="checkbox"/> HMO/POS	<input type="checkbox"/> EPO/POS	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	
Reason for closure	<input type="checkbox"/> Panel Full	<input type="checkbox"/> Part Time	<input type="checkbox"/> Other (explain below)		
"Other" explanation					

<input type="checkbox"/> Facility services	Effective date	
<input type="checkbox"/> End stage renal dialysis <input type="checkbox"/> Free standing surgical center <input type="checkbox"/> Home health care <input type="checkbox"/> Tele-monitoring svcs. <input type="checkbox"/> Home infusion (specify) <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Outpatient infusion <input type="checkbox"/> Hospitals* <input type="checkbox"/> Hospice <input type="checkbox"/> Laboratories <input type="checkbox"/> Long term acute care (LTAC)	<input type="checkbox"/> Mental health <input type="checkbox"/> Inpatient services <input type="checkbox"/> # of CMS beds _____ <input type="checkbox"/> Outpatient services <input type="checkbox"/> Pathology <input type="checkbox"/> Rehab outpatient facilities (specify) <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Physical therapy <input type="checkbox"/> Speech therapy <input type="checkbox"/> School-based health clinic	<input type="checkbox"/> Skilled nursing failities <input type="checkbox"/> # of CMS beds _____ <input type="checkbox"/> Sleep disorder centers <i>AASM accreditation is required</i> <input type="checkbox"/> Substance abuse <input type="checkbox"/> Inpatient services <input type="checkbox"/> # of CMS beds _____ <input type="checkbox"/> Outpatient services <input type="checkbox"/> Rural health clinic <input type="checkbox"/> Urgent care facilities
*Hospital services – please list any additional services from above on the list below:		
<input type="checkbox"/> Ambulance <input type="checkbox"/> Dialysis <input type="checkbox"/> Prosthetics/orthotics <input type="checkbox"/> Cardiac surgery program <input type="checkbox"/> Cardiac catheterization svcs.	<input type="checkbox"/> Critical care services / ICU <input type="checkbox"/> # of beds _____ <input type="checkbox"/> Durable medical equipment <input type="checkbox"/> Prosthetics / orthotics <input type="checkbox"/> Bathroom safety bars <input type="checkbox"/> Independent diagnostic svcs.	<input type="checkbox"/> Radiology / imaging centers <input type="checkbox"/> Diagnostic radiology <input type="checkbox"/> Mammography <input type="checkbox"/> Therapeutic radiology

Verify all information is complete and any required supporting documentation is included. Incomplete forms and missing documentation will result in delays.

Fax or e-mail the completed form to the Provider Information Management department.

Fax: 616 975-8857

email: *ph-providerinfomgmt-demographics@priorityhealth.com*