PriorityHealth

Provider change form

About the change					
Provide a brief explanation of the change					
Physician name					
Group / facility name					
Current Tax ID		NPI number		Date	

Person completing this form	
Name	
Phone	
Email	

Type of change			
☐ **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 recontract with the plan for 12 months or until the next contract year, whichever is longer. Visit Office Management and Standards in the Provider Manual at *priorityhealth.com* for more information.			Effective date_____
Networks leaving:	☐ HMO/POS ☐ EPO/POS	☐ Medicaid ☐ Medicare	☐ All products
Reason for leaving:	☐ Deceased ☐ Retiring ☐ Leave of absence ☐ Moving outside the service area ☐ Moving to another participating group		☐ Patients moving with physician ☐ Patients staying at current practice (complete transfer info) ☐ Terming contract ☐Other_____
Extension of Care (EOC):	☐ Yes ☐ No EOC, members remain with group		☐ No EOC, still in network ☐ EOC refused
Physician agrees to transfer his/her members to:	☐ One PCP	Physician name	
	☐ Multiple PCPs	Physician name	
		Physician name	
		Physician name	
How do you want your members divided among multiple PCPs? (Choose one)	☐ Age ☐ Gender ☐ ZIP	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 to “Patient status.”

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☐ **PCP changing to specialist (SCP)**	Effective date	
Will you be doing home visits?	☐ Yes	☐ No
Are you a hospitalist (in the hospital 100% of your time)?	☐ Yes	☐ No
Will you have a private practice location?	☐ Yes	☐ No

☐ **Demographic (address, phone or fax) change**			Effective date	
Name "on the door" of this location				
☐ Add	Term date (last day) old address is valid			
☐ Delete	Effective date new address is valid on			
Address type (check all that apply)	☐ Primary ☐ Secondary	☐ Billing/remit ☐ Tax ID address*	☐ Other ☐ 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)?	☐ Yes ☐ No

☐ **Demographic (address, phone or fax) change**			Effective date	
Name "on the door" of this location				
☐ Add	Term date (last date) old address is valid			
☐ Delete	Effective date new address is valid on			
Address type (check all that apply)	☐ Primary ☐ Secondary	☐ Billing/remit ☐ Tax ID address*	☐ Other ☐ 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)?	☐ Yes ☐ No

*You must include a W-9 for this change. Note: There should be no 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 notify EDI at 800.942.0954 ext. 48686 or *EDISETUP@priorityhealth.com.*

☐ **Name, tax ID* or NPI change**			Effective date	
Current name		New name		
Old dates of service will be billed with:	☐ Old name ☐ New name			
Current Tax ID		New Tax ID*		
Current NPI		New NPI		

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

☐ **Age panel limit change**				Effective date	
New age panel	☐ Family Practice (1 day to 99+ years)	☐ General Practice (1 day to 99+ years)	☐ Gynecology (13 to 99+ years)	☐ Internal Medicine (16 to 99+ years)	
	☐ IM/Pediatrics (1 day to 99+ years)	☐ OB/Gyn (13 to 99+ years)	☐ Pediatrics (1 day to 21 years)	☐ Other	
	If other, age panel requesting:				

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

☐ **Open/close status change** Priority Health must receive changes **60 days** prior to their effective date or claims may be denied (unless otherwise noted).			Effective date	
Opening to	☐ HMO/POS	☐ EPO/POS	☐ Medicaid	☐ Medicare
Closing to	☐ HMO/POS	☐ EPO/POS	☐ Medicaid	☐ Medicare
Reason for closure	☐ Panel full	☐ Part-time	☐ Other (explain below)	
“Other” explanation				

☐ **Facility services**	Effective date	

- ☐ End stage renal dialysis
- ☐ Free standing surgical center
- ☐ Federally Qualified Health Clinic (FQHC)
- ☐ Home health care
  - ☐ Telemonitoring svcs.
- ☐ Home infusion (specify)
  - ☐ Chemotherapy
  - ☐ Outpatient infusion
- ☐ Hospitals*
- ☐ Hospice
- ☐ Laboratories
- ☐ Long term acute care (LTAC)
- ☐ Mental health
  - ☐ Inpatient services
    - ☐ # of CMS beds _____
  - ☐ Outpatient services
- ☐ Pathology
- ☐ Rehab outpatient facilities (specify)
  - ☐ Occupational therapy
  - ☐ Physical therapy
  - ☐ Speech therapy
- ☐ School-based health clinic
- ☐ Skilled nursing failities
  - ☐ # of CMS beds _____
- ☐ Sleep disorder centers
  AASM accreditation is required
- ☐ Substance abuse
  - ☐ Inpatient services
    - ☐ # of CMS beds _____
  - ☐ Outpatient services
- ☐ Rural health clinic
- ☐ Urgent care facilities

***Hospital services – please list any additional services from above on the list below:**

- ☐ Ambulance
- ☐ Dialysis
- ☐ Prosthetics/orthotics
- ☐ Cardiac surgery program
- ☐ Cardiac catheterization svcs.
- ☐ Critical care services / ICU
  - ☐ # of beds _____
- ☐ Durable medical equipment
  - ☐ Prosthetics / orthotics
  - ☐ Bathroom safety bars
- ☐ Independent diagnostic svcs.
- ☐ Radiology / imaging centers
  - ☐ Diagnostic radiology
  - ☐ Mammography
  - ☐ Therapeutic radiology

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

Fax or email the completed form to the Provider Information Management department.

Fax: 616.975.8857
email: *ph-providerinfomgmt-demographics@priorityhealth.com*