

Provider Change Form

Complete the applicable sections below to make changes to an existing provider or organization. Save your completed document for your records. To submit it to us:

1. [Log into your prism account](#)
2. Click on "Enrollments & Changes"
3. Click on "Change Individual Provider or Organization"
4. Follow the directions as indicated

About the provider			
Name/degree		Provider NPI	
DOB		Provider specialty	
Gender		Provider primary hospital ¹	
Group/facility name		Group/facility NPI	
Provider ID/vendor #		Primary billing taxonomy code	
Description of request			

Physician organization (PO)/physician hospital organization (PHO)/Clinically Integrated Network (CIN)			
Is this provider a member of a PO, PHO or CIN?	Yes	No	
If yes, what's the PO, PHO or CIN you're contracted under for this request?			
Will this be your <i>primary</i> PO, PHO or CIN if you participate with more than one?	Yes	No	N/A

Contact/person responsible for completing this form			
Name		Today's date	
Mailing address			
Phone number			
Email address			

Provider's practice setting			
Is the provider changing from a PCP to a specialist?	Yes	No	
Is the provider a hospitalist?	Yes	No	
Is the provider practicing exclusively within the hospital setting?	Yes	No	
Does the provider offer acupuncture services?	Yes	No	
Does the provider offer virtual visits?	Yes, both virtual and physical	Yes, virtual only	No, physical only

Change a group or facility's name, tax ID or NPI			
Current name		New name	
Current tax ID		New tax ID	
Current NPI		New NPI	
Current DBA name		New DBA name	

¹Required field for all primary care providers and specialty care providers except DCs, ODs and BH APPs

Change provider's name			
Current name		New name	

Change PCP age panel limits			
	Family practice (0-99+ years)		General practice (0-99+ years)
	IM/peds (0-99+ years)		Internal medicine (16-99+ years)
	Pediatrics (0-21 years)		Gynecology (13-99+ years)
	OB/Gyn (13-99+ years)		

Product participation status					
	Open to new members	Closed to new members	Reason for closing to new members		
			Panel full	Part-time	Other
HMO					
PPO					
Medicare					
Medicaid					

Product open/closed status (PCP only)					
	Open to new members	Closed to new members	Reason for closing to new members		
			Panel full	Part-time	Other
HMO					
PPO					
Medicare					
Medicaid ²					
Do you participate with Children's Special Health Care Services (CSHCS)?			Yes ³	No	

Demographic information (attach additional addresses to this form)							
Add location ⁴ (must complete demographic information section in full)						Effective date	
Group billing name (name on claim)							
Group "name on the Door" of this location							
Practice website							
Address						City	
State		Zip			County		
Phone				Fax ⁵			
Can Priority Health members call this phone number to make an appointment with the provider at this location?						Yes	No
Address type		Primary				Secondary	
		Billing/remit				Tax (include updated W-9)	
		Other:					
Billing TIN							
Group billing NPI							
Provider's scope at this location		PCP, physician				Specialist, physician	
		Hospitalist/rounding				Assisting in surgeries	
		APP/midlevel PCP				APP/midlevel specialist	
		Behavioral health practitioner				Other:	

²If requesting a new Medicaid contract, you must attach a Medicaid Disclosure Form (page 5)

³If you participate with Children's Special Health Care Services (CSHCS), you must complete the CSHCS Individual or Group Provider Attestation form (pages 6-7)

⁴If this is a new FQHC, RHC or THC location, please submit a prism application for a new organization

⁵You must notify edissetup@priorityhealth.com for any fax number change where electronic claim receipt notices are sent

APP only		
NPI of the supervising Priority Health participating physician with whom the APP holds a current practice agreement (also known as a collaboration agreement)		
How does the APP provider bill?	Bills independently	Bills under a supervising physician

Office hours							
	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Building/facility open hours							

Cross coverage (list covering providers)			
Name, title		Specialty	
Address		Phone	
Name, title		Specialty	
Address		Phone	
Name, title		Specialty	
Address		Phone	
If none, please explain			
Do you currently admit and care for hospitalized patients?	Yes		No
If no, explain the formal inpatient coverage arrangement you have for each inpatient facility			

Type of term – Provider leaving a participating Priority Health Network group. Priority health requires a written notice 90 days in advance. Find requirements and responsibilities in our Provider Manual at priorityhealth.com/provider for more information. (Attach additional address to this form.)

Priority Health maintains that the primary care relationship resides between the member and the PCP. Members will remain with their current PCP if the change of location distance is less than 30 miles. When applicable, Priority Health will reach out to the provider group to determine where members should be transferred. Members will be transferred to a new PCP when any of the following reasons exist:

- Provider deceased or retired
- Provider changes from a PCP to SPC
- PCP moved out of current Priority Health Michigan service area or more than 30 miles from their current primary location
- PCP is no longer participating/contracted
- Age panel limit with member transfer Network termination due to sanction/license suspension

Which of these options apply to this termination?	Removing a location	Leaving a location	Leaving a group	Leaving a PHO
Do you want to terminate your affiliation with the Priority Health Network?	Yes	No	Termination effective date	
Group billing name (name on claim)				
Group "name on the door" of this location				
Group TIN		Type 2 NPI		
Address				
City		State		Zip
Reason for leaving	Deceased		Leave of absence	
	Retired		Moving to another group	
	Moving outside the service area		Moving to another location under the same group	
PCP authorizing EOC?	EOC terms accepted		EOC terms refused	

Behavioral health providers only		
Professional services	Adding service	Terminating service
Domestic violence		
Dual diagnostics		
Gay/lesbian issues		
Post-traumatic stress disorder		
Sexual trauma		
Transgender issues		
Eating disorders		
Opiate addiction treatment		
ADD/ADHD (criteria: Doctorate level, full licensure)		
Psychological testing (criteria: Doctorate level, full licensure)		
EMDR (copy of certificate required)		
Neuropsychology (training and work experience required)		
Autism		
Age panel	Children (0-12 years)	
	Adolescents (12-18 years)	
	Adults (18-99 years)	
	Other (specify):	

Additional services – Select any that apply		
Ambulance	Dialysis	Independent diagnosis services
Anesthesiology group	Diabetes prevention program	Pathology group
Audiology	Durable medical equipment	Prosthetics/orthotics
Hearing aid supplier	Prosthetics	Radiology/imaging centers Diagnostic radiology Mammography Therapeutic radiology
Hearing screenings	Bathroom safety bars	
Cardiac catheterization	Emergency medicine group	
Cardiac surgery program	Health department	Other:
Centering pregnancy	High-tech services including: CT, MRI,	
Critical care services/ICU	PET, etc.	

Provider Change Form acknowledgement – This form will be used as a supplement to the provider's Council for Affordable Quality Healthcare (CAQH) application	
I consent to the release of this information to the Council for Affordable Quality Healthcare (CAQH), for the purpose of allowing Priority Health access to my information in the CAQH Universal Credentialing Data Source (UC).	
By signing this form, I affirm that the information supplied is correct and complete, and that any misstatements in, or omissions from this form may be cause for denial of credentialing.	
Provider agrees by submission of this request to abide by the terms of the Participation Agreement between Priority Health and the designated accountable care network entity listed on Page 1.	
Physician/representative signature	Your typed name confirms your electronic signature

Before you submit this form:

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

Medicaid Disclosure Requirement Form for Medicaid Network Providers

Federal Regulation # 42 CFR §455.106(a), 42 CFR §455.101 and 42 CFR §455.104

Provider Group/Organization Name: _____

Provider Name: _____

Signature of person completing this form: _____ **Date:** _____

Has any person who has ownership or control interest in the provider, or is an agent or managing employee of the provider, ever been convicted of a criminal offence related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of these programs?

No

Yes – If yes, please list below:

	First name	Middle initial	Last name
1.			
2.			
3.			

Managing employee section

Please provide the name, Social Security number and home address for any employee who meets the definition of managing employee.*

	First name/Middle initial/Last name	Social Security Number	Home Address
1.			
2.			
3.			

Ownership section

Please provide the name, Social Security number and home address for all owners with 5% or more ownership or control interest in the entity. (See 42 CFR §455.104)

	First name/Middle initial/Last name	Social Security Number	Home Address
1.			
2.			
3.			

* Managing employee is defined in 42 CFR §455.101 as a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Children's Special Health Care Services (CSHCS) Provider Attestation

The undersigned primary care physician hereby certifies as follows:

1. I currently serve children or youth with complex chronic health conditions.
2. My practice has implemented a procedure to identify children or youth with chronic health conditions.
3. My practice will provide expanded appointments when a child or youth patient has complex needs and requires more time.
4. My practice coordinates care for children or youth who receive services from multiple professionals including, but not limited to, pediatric subspecialists, physical therapists and mental health professionals.
5. My practice is open to (select one):
 - New patients (children or youth) with complex chronic health conditions
 - Existing patients (children or youth) with complex chronic health conditions

Date: _____

Signature: _____

Printed name: _____

NPI number: _____

Children's Special Health Care Services (CSHCS) Provider Group Attestation

The undersigned single signature authority hereby certifies that physicians within
_____ **(Group Name):**

1. Currently serve children or youth with complex chronic health conditions.
2. Their practices have implemented a procedure to identify children or youth with chronic health conditions.
3. Their practices will provide expanded appointments when a child or youth patient has complex needs and requires more time.
4. Their practices coordinate care for children or youth who receive services from multiple professionals including, but not limited to, pediatric subspecialists, physical therapists and mental health professionals.
5. My practice is open to (select one):
 - New patients (children or youth) with complex chronic health conditions
 - Existing patients (children or youth) with complex chronic health conditions

Date: _____

Signature: _____

Printed name (Single Signature Authority): _____

NPI number: _____