Practitioner Information Change Request Form

Please use this form to indicate any changes in your practice. Attach any additional documentation to support the changes and submit all documents by email to efax_ProviderReimbursement@cdphp.com or fax them to (518) 641-3209.

Practitioner Information

Practitioner Name: _____

Name Change? ☐ Yes ☐ No (Former name): _____

Individual NPI #: _____ **Note:** Your Medical License ***must*** show name change.

Asterisk (*) denotes required field. Double asterisk (**) denotes required fields for PCPs.

Practitioner Scope*

☐ **NP** ☐ **PA** ☐ **MD** ☐ **DO** ☐ **Other:** _____ Telemedicine: ☐ Yes ☐ No

NP or PA: Must provide name of collaborating/sponsoring MD: _____

☐ **PCP** ☐ **Specialist** ☐ **PCP & Specialist** ☐ **Urgent Care** ☐ **Hospitalist**

PCP Office hours**: _____ Total # of hours the PCP is available at the office**: _____

Enhanced Primary Care Site (EPC)** ☐ Yes ☐ No If yes, indicate site NPI#: _____

☐ **Behavioral Health (BH) practitioner** *Please select age range of BH patients:*

☐ Treats Children (Under 18) ☐ Treats patients 18+ yrs ☐ Treats All Ages

****Please select at least one (max of 8) BH area(s) of focus from the bottom of this page (required).*

Triple asterisk (***) denotes required fields for behavioral health providers.

Type of Practice Change

Please select all fields that apply.

Signature of practitioner or office manager is required.

See the next page for Roster Template.

☐ Add Practitioner(s): _____

☐ Adding a new physical office location: _____

☐ New Tax ID #: _____ or ☐ TIN Change (W9 Required) _____

(If submitting changes for muiltiple practitioners or practices, please complete the Provider Roster form an email or fax it with this Provider Information Change Request Form.)

☐ Leaving a physical office location ☐ Leaving a Group Practice

☐ Moving from one physical office location to another (same TIN)

☐ Termination request—Group (must attach Provider Roster)

☐ Termination Notice—Individual (Ex: retired, moved out of area, no longer wants to participate with CDPHP)

☐ Moving from one physical office location to another (different TIN; W9 required)

If PCP, indicate who members should be moved to: _____

☐ Termination Notice—Line of Business (LOB). Please specify LOB: _____

Former practice name: (If Applicable) _____

Former practice termination date: ___ /___ /_____ (mm/dd/yyyy) Tax ID#: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

New practice information: _____

New practice effective date: ___ /___ /_____ (mm/dd/yyyy) Remit NPI#: _____

Address Line 1: _____

Address Line 2: _____ Tax ID #: _____

City: _____ State: _____ Zip: _____

Phone: (___) ___ - ____ Fax: (___) ___ - ____ Provider Email: _____

Which of the following are accessible to handicapped patients at your practice? (Select all that apply.)*:

☐ Building ☐ Parking ☐ Restroom

List all current hospital affiliations*: _____

What lines of business do you participate in with CDPHP? (Select all that apply.)*:

☐ Commercial ☐ Medicare ☐ Medicaid (Active MMIS # required to par with Medicaid except for LMHC, LMFT, BCBC, ABA, Acu, and RD Practitioners) MMIS#: _____

☐ Essential Plan

Can patients schedule an appointment with you at this site?* ☐ **Yes** ☐ **No**

Is the provider accepting new patients?* ☐ **Yes** ☐ **No** **If yes, select all applicable lines of business:**

☐ Commercial ☐ Medicare ☐ Medicaid ☐ Essential Plan

Are any languages other than English spoken by the provider? ☐ **Yes** ☐ **No**

Please specify: _____

(continued on next page)

(continued from previous page)

Is this site a nursing home?* ☐ **Yes** ☐ **No** **Is this site for inpatient services only?*** ☐ **Yes** ☐ **No**

Are there restrictions in terms of types of patients/services at the practice?* (e.g., age, diagnostic services only)

☐ **Yes** ☐ **No** **Please specify:** _____

Correspondence/ Remit Address

(All CDPHP correspondence will be sent to this address.)

☐ Correspondence address change ☐ Use primary address for correspondence.

☐ Remit change (W9 required)

Effective Date: ___ /___ /_____ (mm/dd/yyyy)

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

PLEASE UPDATE CAQH WITH ALL CHANGES

Office Manager: _____ Signature: _____

Date: _____ Phone #: _____

Practitioner: _____ Signature: _____

Date: _____ Phone #: _____

SIGNATURE OF PRACTITIONER OR OFFICE MANAGER IS REQUIRED.*

Behavioral Health Providers: Area(s) of Focus

Choose all that apply (max. of 8)

☐ Abuse, assault, and trauma
☐ Adoption
☐ Anxiety and panic disorders
☐ Attention deficit hyperactivity disorder
☐ Autism spectrum disorders
☐ Bariatric assessment
☐ Behavior modification
☐ Bipolar disorders
☐ Chemical dependency/drug addiction
☐ Christian counseling
☐ Cognitive behavioral therapy
☐ Compulsive gambling
☐ Cultural/ethnic issues
☐ Depression
☐ Dialectical behavioral therapy (DBT)
☐ Dissociative disorders
☐ Divorce/blended family issues
☐ Eating disorders
☐ Electroconvulsive therapy (ECT)
☐ End-of-life issues
☐ Eye movement desentization reprocessing (EMDR)
☐ Family therapy
☐ Gay/lesbian/bisexual issues
☐ Gender identification/transgender issues
☐ Geriatrics
☐ Grief/bereavement
☐ Group therapy
☐ HIV/AIDS-related issues
☐ Infertility
☐ Men's issues
☐ Obsessive compulsive disorders
☐ Pain management
☐ Personality disorders
☐ Postpartum issues
☐ Schizophrenia/psychotic disorders
☐ Sexual disorders
☐ Women's issues