Provider demographic update information form

All fields with Asterix are mandatory. Please complete this form in its entirety and use "N/A" if not applicable.*

Provider Information		
*Group Name / Facility Name / Legal Name:	*Group Tax ID:	
*Last Name:	*First Name:	*Provider's NPI:
☐**Service Location Add:** ***If more than one office, please attach roster of all locations. (Address, phone, fax, LOBs)***		
Address: Phone: Fax:	Applicable lines of business: ☐Medicaid ☐Marketplace ☐Duals ☐Medicare ☐CHP	Does this provider perform PCP duties at this location? ☐ Yes ☐ No Is this location a FQHC? ☐ Yes ☐ No
☐**Service Location Term:**		
Address:	Term Date:	
Does this require a member move? ☐No ☐Yes (please fill out box to the right)	☐ Members staying with same provider at other active location: ☐ Members to be moved to another provider: Provider Name: Provider NPI: Address: *Please include terming provider approval to move members to an alternative provider	
☐**Age Restriction Update:**		
Age Restriction: From: _____To: _____	Does this apply to all locations? ☐Yes ☐No. Please specify which location(s):	
Does this require a member move? ☐No ☐Yes (please fill out box to the right)	Members outside of age restriction to be moved to another provider: Provider Name: Provider NPI: Address:	

☐ **Open / Close Panels:**		
☐ Open Panels ☐ Close Panels	Does this apply to all locations? ☐ Yes ☐ No. Please specify which location(s):	Applicable lines of business: ☐ Medicaid ☐ Marketplace ☐ Duals ☐ Medicare ☐ CHP
☐ **Specialty Change**		
Add Specialty (description and taxonomy): Remove Specialty:		
☐ **Phone or Fax Number Update:**		
Address: Phone: Fax:		
☐ **Supervising Physician Update:**		
Remove Supervising Physician: Name: NPI: Add Supervising physician: Name: NPI:		
☐ **Other, please be as detailed as possible:**		