PROVIDER INFORMATION CHANGE FORM

For Partnership Use Only
PR Rep: _____
Partnership: _____
☐ PCP ☐ SPEC ☐ Other
☐ Non Visit Directory

Practice/Facility Name as Currently Listed in Provider Directory:	**County:**	**Billing NPI #**	
Street:	City:	State:	Zip:

Instructions: Please indicate the type of change you would like to make and complete all the information in the corresponding section of the form.

☐ Change Practice Name, Address, Phone, or Fax – **Section A** ☐ Change Tax ID or NPI – **Section B** ☐ Change Pay to information – **Section C**	☐ Change Member Assignment (PCP Only) – **Section D** ☐ Change Office Hours – **Section E** ☐ Change information for an individual practitioner (name, employment status, location, languages spoken) – **Section F**

To add a *NEW PRACTITIONER*, please contact Credentialing at credentialing@partnershiphp.org to initiate the process.
To add a *NEW LOCATION* to an existing group, please contact Contracting@partnershiphp.org

This form will be considered incomplete and will delay processing if information, and/or an effective date and signature are missing.

A. Practice Information: Check all that apply and provide information requested

☐ **Change Practice Name to:**				
☐ **Change Service Location to:**	Street:	City:	State:	Zip:
☐ **Change Telephone # to:**		☐ **Change Fax # to:**		

B. Change of Taxpayer Identification Number (TIN) or National Provider Identifier (NPI)

☐ **Change TIN from:**	Old#	**to:**	New #	***A new W-9 Must be attached for change to be processed**
☐ **Change NPI from:**	Old#	**to:**	New #	***Proof of Medi-Cal Must be attached for change to be processed**

C. Change Pay to Address: Changes that directly impact the issuance of your 1099 requires the submission of a NEW W-9 with this form

Name:			
Street:	City:	State :	Zip:
Phone:	Fax:	Effective Date:	

D. Change to Member Assignment (select one) For PCPs Only

☐ **Accepting New Patients:** In addition to your current patients, new Partnership members and members who are selecting a new provider can select your practice without restrictions.

□ 0 – 18 years □ 19 years and over □ 0 – 999 years

☐ **Accepting New Patients with Auto-Assignments:** In addition to your current patients, new Partnership members may select your practice and/or Partnership members who have not selected a Primary Care Physician (PCP) may be assigned automatically to your practice based on zip code.

☐ **Accepting Existing Patients**: Partnership members who have an existing or past relationship or have a family link with your office can request to be assigned to your practice. Members who lose and then regain eligibility are automatically re-linked to their last PCP. For any exception, Partnership must receive verbal or written approval from your office prior to assigning new members that do not qualify for relink or family link to your practice.

☐ **Not Accepting New Patients:** Practice closed to all **new** Partnership members. Members who lose and then regain eligibility *will be* re-linked to their last PCP.

E. Change of Office Hours: Indicate when a patient can call to make an appointment e.g., 8 a.m. – 5 p.m. (Lunch hour not listed in directory) Select CLOSED if closed for the full day only

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
_____ □ a.m. □ p.m. to _____ □ a.m. □ p.m. □ Closed	_____ □ a.m. □ p.m. to _____ □ a.m. □ p.m. □ Closed	_____ □ a.m. □ p.m. to _____ □ a.m. □ p.m. □ Closed	_____ □ a.m. □ p.m. to _____ □ a.m. □ p.m. □ Closed	_____ □ a.m. □ p.m. to _____ □ a.m. □ p.m. Closed	_____ □ a.m. □ p.m. to _____ □ a.m. □ p.m. Closed	_____ □ a.m. □ p.m. to _____ □ a.m. □ p.m. Closed

F. Change Information for an Individual Practitioner within your organization:

Practitioner Name:	**Title:**	**NPI:**

Change in Employment Status or Location within your organization: (check one)

☐ **Retired** – Effective Date: ☐ **Terminated Employment/Resigned** – Effective Date:

☐ **Moved or added additional site(s)** – Effective date: _____

Check the appropriate box below for moving an individual provider and complete ALL applicable information.

☐ The Provider has moved from one site to another within your organization.

Remove provider from Directory Listing at this location: _____

Add provider to Directory Listing(s) at this location: _____

☐ The provider is rendering services at an additional location(s) within your organization.

List locations within the directory to include this provider: _____

Change Languages Spoken by Practitioner: Please use this section to make any language corrections necessary for the directory.

☐ Add: ☐ Delete:

Change Practitioner Name: Please use this section to make any spelling corrections necessary for the directory.

Current Spelling:	Correct Spelling:

Member Notification: Per DHCS, members must be notified in writing of any significant changes in the **availability or location** of covered services, or any significant change in information. (e.g. change of address, phone number, or office hours)

Were members notified of the change(s) represented on this form?

□ **Yes -** Please attach a copy of the notification □ **No**

How were members notified?

☐ Mailed letters to members ☐ Posted notice on the front window/in the lobby ☐ Phone call to members

Explanation of Changes listed above:

Information Verification

I hereby affirm that the information submitted in this application is correct and complete to the best of my knowledge and belief, and is furnished in good faith.

☐ **Please process the changes listed above with the effective date of** _____

Printed Name of Person Completing Form: _____ Date: _____

Signature: _____ Title: _____

Contact Email: _____ Contact Phone: _____

Return this form to the Provider Relations Department by either submitting to your Provider Relations representative, faxing the form to (707) 639-5503, or by clicking the Submit Button to email form.

Submit **Clear Form**