CLEAR FORM

# STANDARDIZED PROVIDER INFORMATION CHANGE FORM

COMPLETE ALL APPLICABLE INFORMATION. INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.

**NOT FOR NEW PROVIDERS OR CONTRACTUAL OR CREDENTIALING CHANGES.**

## *1. INDICATE CHANGE(S) BEING SUBMITTED: *(Check all that apply — please include effective date for each item checked.)*

***Section required.***

| | Effective date | | Effective date |
|---|---|---|---|
| ☐ Practice Information *(Complete Sections 2, 3, 6)* | | ☐ Practice Status *(Complete Sections 2, 4, 6)* | |
| ☐ Billing Information *(Complete Sections 2, 3, 6)* | | ☐ Termination *(Complete Sections 2, 5, 6)* | |
| ☐ Provider Name *(Complete Sections 2, 6)* | | | |

Indicate Documents Included: ☐ W9 ☐ Provider Roster ☐ Other _____

***PLEASE COMPLETE THE APPLICABLE SECTIONS BELOW TO UPDATE YOUR INFORMATION.***
***IF CHANGING TAX INFORMATION, YOU ARE REQUIRED TO SUBMIT AN UPDATED W9 WITH THIS FORM.***

## *2. PROVIDER INFORMATION: **Section required.*

| | | | |
|---|---|---|---|
| Provider Last Name: | | First Name: | MI: |
| Provider Former Name *(If Applicable)*: | | | |
| NPI#: | Medicaid ID# *(If Applicable)*: | PTAN# *(If Applicable)*: | TAX ID#: |
| Provider Type: ☐ PCP ☐ Specialist ☐ Both ☐ Hospitalist Only ☐ Ancillary/Allied/Mid-Level | | | |
| Practice/Business Name: | | | |
| Street: | | | |
| City: | | State: | Zip: |
| Phone: | | Fax: | |
| Provider Email Address: | | | |

***IF APPLICABLE, PLEASE ATTACH A SEPARATE LIST WITH THE NAMES AND NPI NUMBERS OF ALL OF THE PROVIDERS IN THIS GROUP FOR WHOM THE ADDRESS CHANGE IS APPLICABLE.***

## 3. ADDRESS INFORMATION:

| ENTER NEW OR ADDITIONAL ADDRESSES BELOW | | ENTER OLD ADDRESSES *TO BE TERMINATED* BELOW | |
|---|---|---|---|
| Address Type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing | | Address Type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing | |
| Address Line 1: | Suite #: | Address Line 1: | Suite #: |
| Address Line 2: | | Address Line 2: | |
| City: | | City: | |
| State: | Zip: | State: | Zip: |
| Phone: | Fax: | Phone: | Fax: |
| Office Hours: | Disability Access: ☐ Yes ☐ No | Office Hours: | Disability Access: ☐ Yes ☐ No |
| Languages Spoken by Provider or Office Staff: | | Languages Spoken by Provider or Office Staff: | |

| | | | |
|---|---|---|---|
| Address Type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing | | Address Type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing | |
| Address Line 1: | Suite #: | Address Line 1: | Suite #: |
| Address Line 2: | | Address Line 2: | |
| City: | | City: | |
| State: | Zip: | State: | Zip: |
| Phone: | Fax: | Phone: | Fax: |
| Office Hours: | Disability Access: ☐ Yes ☐ No | Office Hours: | Disability Access: ☐ Yes ☐ No |
| Languages Spoken by Provider or Office Staff: | | Languages Spoken by Provider or Office Staff: | |

| | |
|---|---|
| Contact Person Completing Form: | Phone: |



*(continued on next page)*

## STANDARDIZED PROVIDER INFORMATION CHANGE FORM (*CONTINUED*)

Provider Name: _____

### 4. PRACTICE STATUS: *May be impacted by contract terms and follow-up may be required.*

Practitioner Availability Status:

- ☐ Accepting New Patients
- ☐ Accepting Existing Patients Only
- ☐ Closed *(Not Accepting New Patients and Not Accepting Existing Patients)*
- ☐ Concierge Practice
- ☐ Nursing Home Only
- ☐ Other *(Please Specify)* _____

Do you offer telemedicine/telehealth (i.e., video visits)? ☐ Yes ☐ No

Do you offer lactation counseling services? ☐ Yes ☐ No

### 5. TERMINATION: *Effective date may be impacted by contract terms and follow-up may be required.*

Reason for termination, please check only one box:

- ☐ Resigned
- ☐ Retired
- ☐ Deceased
- ☐ Leave of Absence*
- ☐ Moved Out-of-State
- ☐ Practice Closed
- ☐ Provider Sanctioned*
- ☐ Sabbatical*
- ☐ Provider Transferred To *(Group Name)* _____
- ☐ Other _____

**Please provide a separate explanation of the details to the plan (i.e., duration of absence for leave/sabbatical or sanction specifics).*

### *6. CONTACT PERSON SUBMITTING INFORMATION: **Section required.*

| | |
|---|---|
| Name: | Title: |
| Phone: | Fax: |
| Email: | |
| Date of Submission: | |

### SUBMISSION INFORMATION:

| | | |
|---|---|---|
| Blue Cross Blue Shield of MA<br>Provider Enrollment Dept.<br>PO Box 55350<br>Boston, MA 02205-5350<br>Email: provider-enrollment@bcbsma.com<br>Fax: (617) 246-7771<br>Phone: (800) 316-BLUE (2583) | Fallon Health<br>One Chestnut Place<br>10 Chestnut Street<br>Worcester, MA 01608<br>Email: askfchp@fchp.org<br>Fax: (508) 368-9902<br>Provider Services: (866) 275-3247, opt. 4 | Harvard Pilgrim Health Care<br>Attn: Provider Processing Center<br>1600 Crown Colony Drive<br>Quincy, MA 02169<br>Email: PPC@point32health.org<br>Fax: (866) 884-3843<br>Provider Service Center: (800) 708-4414 |
| Health New England<br>Attn: Provider Enrollment Department<br>One Monarch Place, Suite 1500<br>Springfield, MA 01144<br>Email: penrollment@hne.com<br>Fax: (413) 233-2665<br>Phone: (800) 842-4464, ext. 3344 | Mass General Brigham Health Plan<br>Attn: Claims Adjustments, Appeals,<br>and Correspondence<br>399 Revolution Drive, Suite 810<br>Somerville, MA 02145<br>Fax: (617) 526-1902 | Tufts Health Public Plans<br>Provider Information Department<br>1 Wellness Way<br>Canton, MA 02021<br>Email: provider_data_request@point32health.org<br>Fax: (857) 304-6311 |
| Tufts Health Plan<br>Provider Information Department<br>1 Wellness Way<br>Canton, MA 02021<br>Email: provider_information_dept@<br>point32health.org<br>Fax: (617) 972-9044 | Senior Whole Health<br>Attn: Provider Relations<br>58 Charles Street<br>Cambridge, MA 02141<br>Email: providerrelations@seniorwholehealth.com<br>Fax: (617) 551-4185<br>Phone: (617) 494-5353 | UniCare<br>Provider Relations Department<br>PO Box 9022<br>Andover, MA 01810<br>Email: unicareproviderrelations@wellpoint.com<br>Fax: (978) 474-6188<br>Phone: (800) 480-7587 |
| WellSense Health Plan<br>Provider Processing Center<br>529 Main Street, Suite 500<br>Charlestown, MA 02129<br>Email: BMCHP.providerprocessingcenter@<br>bmchp.org<br>Fax: (617) 897-0818<br>Provider Processing Center: (888) 566-0008 | | |

**IF APPLICABLE, SUBMIT COPY OF COMPLETED FORM TO IPA/PHO COORDINATOR OR ADMINISTRATOR.**