



MEDICARE ADVANTAGE STANDARDIZED PROVIDER INFORMATION CHANGE FORM

COMPLETE ALL APPLICABLE INFORMATION AND UTILIZE 'SUBMIT' BUTTON BELOW.
INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.

NOT FOR NEW PROVIDERS, CONTRACTUAL MODIFICATIONS, OR CREDENTIALING CHANGES

*** 1. INDICATE CHANGE(S) BEING SUBMITTED: Check all that apply (*Sections 1,2 and 5 are required.)**
Please include effective date for each item checked.

Provider Information (Complete sections 2,3,5) Effective Date: _____ Panel Status (Complete sections 2,4,5) Effective Date: _____
 Address Information (Complete sections 2,3,5) Effective Date: _____ Group Name (Complete sections 2,5) Effective Date: _____

Indicate documents included: Provider Roster Other (List): _____

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

Last Name: _____ First Name: _____ Middle Initial: _____ Gender: Male Female
 Provider Former Name (if applicable): _____ Title/Degree: _____
 Primary Specialty: _____ IND NPI: _____
 Secondary Specialty(ies): _____ EPSDT (If applicable): Yes No Accept Medicare & Medicaid: Yes No
 Hospital Accreditation: _____
 Hospital Affiliation 1: _____ 2: _____ 3: _____
 Board Certification 1: _____ 2: _____ 3: _____
 Language 1: _____ 2: _____ 3: _____
 Provider Type: PCP Ancillary Behavior Health Facility LTSS Specialist
 Address Line 1: _____
 Address Line 2: _____
 City: _____ State: _____ County: _____ Zip Code: _____
 Provider Email Address: _____ Phone: () _____

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

Product: MA MMP PPO PSP Medicaid All Products

Group Name: _____ Group NPI: _____ Group TAX ID: _____

| ENTER NEW OR ADDITIONAL ADDRESS BELOW | | | | ENTER OLD ADDRESSES TO BE TERMINATED BELOW | | | |
|---|--|---|--|---|--|---|--|
| Address Type: <input type="checkbox"/> Primary Service <input type="checkbox"/> Secondary Service | | Address Type: <input type="checkbox"/> Primary Service <input type="checkbox"/> Secondary Service | | Address Type: <input type="checkbox"/> Primary Service <input type="checkbox"/> Secondary Service | | Address Type: <input type="checkbox"/> Primary Service <input type="checkbox"/> Secondary Service | |
| <input type="checkbox"/> Correspondence | | <input type="checkbox"/> Correspondence | | <input type="checkbox"/> Correspondence | | <input type="checkbox"/> Correspondence | |
| Address Line 1: _____ | | Address Line 1: _____ | | Address Line 1: _____ | | Address Line 1: _____ | |
| Address Line 2: _____ | | Address Line 2: _____ | | Address Line 2: _____ | | Address Line 2: _____ | |
| City: _____ | | City: _____ | | City: _____ | | City: _____ | |
| State: _____ County: _____ Zip: _____ | | State: _____ County: _____ Zip: _____ | | State: _____ County: _____ Zip: _____ | | State: _____ County: _____ Zip: _____ | |
| Phone: () _____ Fax: () _____ | | Phone: () _____ Fax: () _____ | | Phone: () _____ Fax: () _____ | | Phone: () _____ Fax: () _____ | |

INFORMATION RELATED TO NEW OR ADDITIONAL SERVICE LOCATION

| Hours Provider available at this location | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|--|--|--|--|--|--|--|
| Open: | | | | | | | |
| Close: | | | | | | | |
| Patient Center Medical Home | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Location easily accessible via public transportation | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Designated parking for disabled | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Wheelchair ramps | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Waiting room accommodate patients in wheelchairs/scooters | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If radiology offered, accessible to disabled patients | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Materials available in braille and large print | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |



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| 3. ADDRESS INFORMATION | |
|---|--|
| Product: <input type="checkbox"/> MA <input type="checkbox"/> MMP <input type="checkbox"/> PPO <input type="checkbox"/> PSP <input type="checkbox"/> Medicaid <input type="checkbox"/> All Products | |
| Group Name: _____ | Group NPI: _____ Group TAX ID: _____ |
| ENTER NEW OR ADDITIONAL ADDRESS BELOW | ENTER OLD ADDRESSES TO BE TERMINATED BELOW |
| Address Type: <input type="checkbox"/> Primary Service <input type="checkbox"/> Secondary Service <input type="checkbox"/> Correspondence | Address Type: <input type="checkbox"/> Primary Service <input type="checkbox"/> Secondary Service <input type="checkbox"/> Correspondence |
| Address Line 1: _____ | Address Line 1: _____ |
| Address Line 2: _____ | Address Line 2: _____ |
| City: _____ | City: _____ |
| State: _____ County: _____ Zip: _____ | State: _____ County: _____ Zip: _____ |
| Phone: () _____ Fax: () _____ | Phone: () _____ Fax: () _____ |

| INFORMATION RELATED TO NEW OR ADDITIONAL SERVICE LOCATION | | | | | | | |
|---|--|---------|-----------|---|--------|--|--------|
| Hours Provider available at this location | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| Open: | | | | | | | |
| Close: | | | | | | | |
| Patient Center Medical Home | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Location marked and visible from street | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Location easily accessible via public transportation | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Accessible to members with disabilities | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Designated parking for disabled | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Restrooms accessible for people with disabilities | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Wheelchair ramps | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Auto-open external doors | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Waiting room accommodate patients in wheelchairs/scooters | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Exam rooms with accessible equipment | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If radiology offered, accessible to disabled patients | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | ADA compliance on service animals | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Materials available in braille and large print | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | ASL interpretation available | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| 4. PRIMARY CARE PANEL STATUS: <i>May be impacted by contract terms and follow-up may be required.</i> | |
|---|---|
| <input type="checkbox"/> Open panel | <input type="checkbox"/> Close panel |
| <input type="checkbox"/> Nursing home only | <input type="checkbox"/> Accepting existing patients only |
| <input type="checkbox"/> Other (please specify): _____ | |

| * 5. CONTACT PERSON SUBMITTING INFORMATION: *Section required. | |
|--|---------------------------|
| Name: _____ | Title: _____ |
| Phone: () _____ | Fax: () _____ |
| Email: _____ | Date of Submission: _____ |



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