



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

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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