



# 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 <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: _____	State: _____		County: _____
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		



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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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