



Instructions: “Provider” identified sections are for updates related to the rendering practitioner. For updates related to the Practice/Group please use the sections identified as “Practice.” Complete all applicable sections related to your update. If a section does not apply, please indicate with N/A.

Before submitting this form, ensure the CAQH “credentialing application” is current, complete, and includes all required supporting documentation. Community Health Options contracts with Verisys as our credentialing verification organization (CVO). If additional information is needed during the credentialing verification process, Verisys will reach out to the contact listed in [CAQH](#).

Form Completion Information	
Form Completed By:	Form Completion Date:
Email:	Phone:

Provider Information			
Add Provider: Yes No	Change Provider: Yes No	Term: Yes No	
Effective Date:	Effective Date:	Effective Date:	Reason:
First Name:	MI:	Last Name:	Gender:
Date of Birth:	SSN:	Email:	License:
Primary Specialty:	Board Certified:		
Provider NPI:	CAQH Number:		
Locum Tenens: Yes No	If yes, dates of coverage: Start:		End:
*Per NCQA: If <60 days, provider will be provisionally credentialed. If >60 days, will require full credentialing.			

Practice Information Location #1			
Add Practice: Yes No	Change Practice: Yes No	Term: Yes No	
Effective Date:	Effective Date:	Effective Date:	Reason:
Contracted Entity Name:	Practice Name:		
Practice Email Contact:			
Address Line 1:	Address Line 2:		
City:	State:	Zip Code:	
Phone:	Fax:		
Practice NPI:	Practice Tax ID:		
Practice As: PCP Specialist Hospitalist	Accepting New Patients: Yes No		
Languages Spoken by Office Staff:			
Are services provided via telehealth only? Yes No	If no, do you offer telehealth? Yes No		
*Must be licensed in the state the Member is located in			

- Check if the address for Billing is the same as Practice Location #1
- Check if the Utilization Management (member auth contact) address is the same as Practice Location #

Billing Information					
Add Billing:	Yes	No	Change Billing:	Yes	No
Effective Date:			Effective Date:	Reason:	
Name:			Email:		
Address Line 1:			Address Line 2:		
City:			State:		Zip Code:

Utilization Management (For Communication on Member Authorization)					
Add UM:	Yes	No	Change UM:	Yes	No
Effective Date:			Effective Date:	Reason:	
Name:			Email:		
Address Line 1:			Address Line 2:		
City:			State:		Zip Code:
Authorization Phone:			Authorization Fax:		

Practice Information Location #2					
Add Practice:	Yes	No	Change Practice:	Yes	No
Effective Date:			Effective Date:	Reason:	
Contracted Entity Name:			Practice Name:		
Practice Email Contact:					
Address Line 1:			Address Line 2:		
City:			State:		Zip Code:
Phone:			Fax:		
Practice NPI:			Practice Tax ID:		
Practice As:	PCP	Specialist	Hospitalist	Accepting New Patients:	Yes No
Languages Spoken by Office Staff:					
Are services provided via telehealth only? Yes No If no, do you offer telehealth? Yes No					
*Must be licensed in the state the Member is located in					

Note: If you need to add more than 2 locations, use the Roster Template located on our website <https://healthoptions.org/providers/resources/>

Please leave any additional comments or information below that may be relevant: