PROVIDER CREDENTIALING AND CHANGE FORM

Note: This form is for Contracted Providers only. All fields on this form must be completed prior to submission

FORM COMPLETION INFORMATION					
Form Completed By:		Form Completed Date:			
Email:					
Mailing Address Line 1:		Mailing Address Line 2:			
City:		State:		Zip:	
Phone:		Fax:			

PROVIDER INFORMATION		
Provider Add: ☐ Yes ☐ No Effective Date:	Provider Change: ☐ Yes ☐ No Effective Date:	Provider Delete: ☐ Yes ☐ No Effective Date: Reason: Select reason from list below

Last Name:		First Name:		Middle Initial:	
Gender:		Date of Birth:		SSN:	
Email:		Degree: (MD, DO, DC, APRN, NP, ND, etc.)			
Provider Specialties:					
Individual NPI:		CAQH Number:			
Locum Tenens? ☐ Yes ☐ No	If yes, dates of coverage: Start:		End:		

PRACTICE INFORMATION LOCATION #1		
Practice Add: ☐ Yes ☐ No Effective Date:	Practice Change: ☐ Yes ☐ No Effective Date:	Practice Delete: ☐ Yes ☐ No Effective Date:

Contracted Entity Name:					
Practice Name:					
Practice Address Line 1:		Practice Address Line 2:			
City:		State:		Zip:	
Practice Phone:		Practice Fax:			
Group NPI:		Tax ID:			
Practice as: ☐ PCP ☐ Specialist	Accepting New Patients: ☐ Yes ☐		In Directory: ☐ Yes ☐ No		
Languages spoken by office staff:					

PRACTICE INFORMATION LOCATION #2		
Practice Add: ☐ Yes ☐ No Effective Date:	Practice Change: ☐ Yes ☐ No Effective Date:	Practice Delete: ☐ Yes ☐ No Effective Date:

Contracted Entity Name:					
Practice Name:					
Practice Address Line 1:		Practice Address Line 2:			
City:		State:		Zip:	
Practice Phone:		Practice Fax:			
Group NPI:		Tax ID:			
Practice as: ☐ PCP ☐ Specialist	Accepting New Patients: ☐ Yes ☐ No		In Directory: ☐ Yes ☐ No		
Languages spoken by office staff:					

PRACTICE INFORMATION LOCATION #3		
Practice Add: ☐ Yes ☐ No Effective Date:	Practice Change: ☐ Yes ☐ No Effective Date:	Practice Delete: ☐ Yes ☐ No Effective Date:

Contracted Entity Name:					
Practice Name:					
Practice Address Line 1:		Practice Address Line 2:			
City:		State:		Zip:	
Practice Phone:		Practice Fax:			
Group NPI:		Tax ID:			
Practice as: ☐ PCP ☐ Specialist	Accepting New Patients: ☐ Yes ☐ No		In Directory: ☐ Yes ☐ No		
Languages spoken by office staff:					

PRACTICE INFORMATION LOCATION #4		
Practice Add: ☐ Yes ☐ No Effective Date:	Practice Change: ☐ Yes ☐ No Effective Date:	Practice Delete: ☐ Yes ☐ No Effective Date:

Contracted Entity Name:					
Practice Name:					
Practice Address Line 1:		Practice Address Line 2:			
City:		State:		Zip:	
Practice Phone:		Practice Fax:			
Group NPI:		Tax ID:			
Practice as: ☐ PCP ☐ Specialist	Accepting New Patients: ☐ Yes ☐ No		In Directory: ☐ Yes ☐ No		
Languages spoken by office staff:					

PRACTICE INFORMATION LOCATION #5		
Practice Add: ☐ Yes ☐ No Effective Date:	Practice Change: ☐ Yes ☐ No Effective Date:	Practice Delete: ☐ Yes ☐ No Effective Date:

Contracted Entity Name:					
Practice Name:					
Practice Address Line 1:		Practice Address Line 2:			
City:		State:		Zip:	
Practice Phone:		Practice Fax:			
Group NPI:		Tax ID:			
Practice as: ☐ PCP ☐ Specialist	Accepting New Patients: ☐ Yes ☐ No		In Directory: ☐ Yes ☐ No		
Languages spoken by office staff:					

PRACTICE INFORMATION LOCATION #6		
Practice Add: ☐ Yes ☐ No Effective Date:	Practice Change: ☐ Yes ☐ No Effective Date:	Practice Delete: ☐ Yes ☐ No Effective Date:

Contracted Entity Name:					
Practice Name:					
Practice Address Line 1:		Practice Address Line 2:			
City:		State:		Zip:	
Practice Phone:		Practice Fax:			
Group NPI:		Tax ID:			
Practice as: ☐ PCP ☐ Specialist	Accepting New Patients: ☐ Yes ☐ No		In Directory: ☐ Yes ☐ No		
Languages spoken by office staff:					

Please email to: DataIntegrity@HealthOptions.org

Email Print