Provider Change Form

Please type in your information. We cannot accept handwritten forms. This form is not for demographic changes.

Provider name:	Specialty:
Group and facility name:	
Current tax ID number:	Practitioner type 1 NPI number:
Submission date:	Group NPI number:
Provide a brief explanation of the change:	
Contact person (the individual completing this form)	
Name:	
Phone:	Title:
Email:	Fax:
Change information (please complete appropriate section(s):	

I. Network Termination

Effective date:

Reason for terminating:

- ☐ Deceased
- ☐ Leave of absence
- ☐ Moved to another PHO/PO/ACO
- ☐ Compliance
- ☐ Retiring
- ☐ Moving outside service area
- ☐ Contract termination
- ☐ Other:

Membership (PCP only)

Will the membership be reassigned?

☐ Yes ☐ No

If yes, please provide the name of the provider and provider NPI number.

II. Network Transfer (PCP or Specialist) Please complete transfer letter.

Effective date:

Name of current network:	Name of network transferring to: ☐ Network unknown

Membership (PCP only)

Will the membership remain with the current PCP?

☐ Yes ☐ No

If no, please provide the name of the network and provider NPI number.

III. Other (provide detailed description)

Please submit completed form to provider_development@hap.org.