PROVIDER CHANGE FORM

Use this form for changes to existing provider information.

Note: If you are part of a physician organization/physician hospital organization, do not send this form directly to HAP. All changes must be submitted by your PO/PHO organization.

Instructions

1. This form is a fillable PDF. Please **download** it and complete the fields.

2. Check the appropriate box for the type of change you are submitting. Then refer to sections that need to be completed.

X	For	Complete Sections
	Billing (pay to) address change (only one pay to address per Tax ID allowed)	1, 2
	Leaving HAP and/or HAP CareSource	1, 6
	Office address updates – (adding, changing, deleting locations)	1, 4
	Ownership change	1, 8
	Patient accepting status	1, 5
	Provider type change (e.g., PCP to Specialist, etc.)	1, 5
	Specialty type change or addition	1, 5
	Tax ID (TIN) changes	1, 3
	Transferring networks (physicians)	1, 8
	Other (for information related to demographic updates, terminations, or transfers)	1, 9

3. All changes require a 30-day notice to HAP.

4. We will only accept current W-9 forms (nothing older than 10 years). **Be sure to sign and date the form. Forms are considered incomplete if not signed and dated.**

5. **Email completed Provider Change Form and current, signed and dated W-9 to providernetwork@hap.org. Be sure to put "Provider Change Form" in the subject line. Incomplete forms and incomplete W-9's may be returned.**

IMPORTANT!
Be sure your data in the National Plan & Provider Enumeration System (NPPES) is accurate! To verify your information, log in at the **NPPES website**. When reviewing, pay close attention to:

- Provider name
- Mailing address
- Telephone and fax numbers
- Specialty
- Taxonomy
- Practice locations no longer use

April 2024

Section 1
Must be completed by all providers – all fields required

PROVIDER INFORMATION		
Provider full name:		Degree:
Practice name (if applicable):		
NPI Type 1 (individual):	NPI Type 2 (group):	Tax ID:
Network (physician hospital organization): (if applicable)		
Specialty/Service:		

CONTACT INFORMATION (PERSON SUBMITTING FORM)	
First & last name:	
Title:	
Contact phone:	Contact fax:
Contact email:	

Section 2
Billing (Pay To) Address Change

Update billing (pay to) address for Tax ID (TIN):

Street:

City, ST, zip:

Phone: Fax:

Email:

Effective date of change:

Note: Only one pay to address per Tax ID allowed. Be sure to submit current W-9. It must be signed and dated.

Section 3
Tax ID (TIN) Changes

Delete TIN(s):

Add TIN(s):

Be sure to submit a current W-9 for each TIN being added. It must be signed and dated.

Section 4
Office Address Updates

☐ **Add address below** ☐ **Delete address below** ☐ **Make update to existing address below (indicate in comments update made)**

TIN:

Street/Suite:

City, ST, Zip:

Phone: Fax: Email:

Website:

Is this your primary address? ☐ Yes ☐ No Telehealth services offered? ☐ Yes ☐ No

Hours: M: T: W: Th: F: S: S:

Effective date of change:

Comments:

☐ **Add address below** ☐ **Delete address below** ☐ **Make update to existing address below (indicate in comments update made)**

TIN:

Street/Suite:

City, ST, Zip:

Phone: Fax: Email:

Website:

Is this your primary address? ☐ Yes ☐ No Telehealth services offered? ☐ Yes ☐ No

Hours: M: T: W: Th: F: S: S:

Effective date of change:

Comments:

☐ **Add address below** ☐ **Delete address below** ☐ **Make update to existing address below (indicate in comments update made)**

TIN:

Street/Suite:

City, ST, Zip:

Phone: Fax: Email:

Website:

Is this your primary address? ☐ Yes ☐ No Telehealth services offered? ☐ Yes ☐ No

Hours: M: T: W: Th: F: S: S:

Effective date of change:

Comments:

Section 5
Practice Information

PATIENT ACCEPTING STATUS

☐ Close panel to new patients Effective date:
☐ Open panel to new patients Effective date:
Comments:

PROVIDER TYPE OR SPECIALTY CHANGE/ADDITION

☐ PCP changing to Specialist ☐ Specialist changing to PCP
☐ Specialty change From: To:
Adding specialty:

Note: Credentialing may be required for any of these changes.

Section 6
Leaving HAP & HAP CareSource

Reason for leaving:

☐ Deceased ☐ Moving out of state ☐ Retiring ☐ Leave of absence (dates):

Effective date of change:

If PCP, move membership to:

Physician name: NPI:

Note: Depending on your contract arrangement, membership may be assigned to another PCP in your physician organization. Members can only be assigned to one PCP. You cannot divide among physicians.

Section 7
Physician Transferring Networks

PRIMARY CARE PHYSICIAN TRANSFERRING NETWORKS

Note: If you are part of a physician organization/physician hospital organization, do not send the form directly to HAP. The PO/PHO group medical director or their designee must complete this form.

Current PHO/PO/ACO:

Move to PHO/PO/ACO:

☐ Unknown PHO/PO/ACO

Membership transferring to new physician?

☐ **Yes, transfer to (physician name):** **NPI:**

☐ **No,** move with current PCP to new PHO/PO/ACO

Effective date:

SPECIALIST UPDATES TO NETWORKS

Remove from:

Add to:

☐ Unknown

Section 8
Change in Ownership

CURRENT	UPDATE REQUESTED
Current provider name:	New provider name:
Current DBA name:	New DBA name:
NPI Type 1: NPI Type 2:	NPI Type 1: NPI Type 2:
Current TIN:	New TIN:
Current facility/office address:	New facility/office address:
Current billing address:	New billing address:

Section 9
Other Information

Use this page for any other information related to demographic updates, terminations, or transfers.