

Provider Change Form

Group/Practice: _____

Provider(s) Name(s): _____

Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Change in Group Name | <input type="checkbox"/> Add a Physician to a group ** |
| <input type="checkbox"/> New Tax ID Number | <input type="checkbox"/> Provider Leaving the Practice (see below) |
| <input type="checkbox"/> Additional Office Location | <input type="checkbox"/> Board Certification Completion |
| <input type="checkbox"/> Physical Address Change | <input type="checkbox"/> Telephone/Fax Change |
| <input type="checkbox"/> Billing Address Change | <input type="checkbox"/> Other |

Effective Date of Change: _____

PCP's only Panel Status: Open Closed Existing Patients Only

Address Information: _____

City: _____ State: ____ Zip: _____

Previous Tax ID Number: _____

New Tax ID Number: _____

Note: For tax ID changes, please include a copy of your W-9 form.

Telephone Number: () _____

Fax Number: () _____

Contact Person: _____

Provider Leaving the Practice:

Retirement? Yes No

Relocating? Yes No

Where?

City: _____ State: _____

****Please include credentialing application and attachment and/or CAQH form and current copy of CV**

Please send completed form to Network Management and Provider Operations:

Fax: (207) 828-7870

Mail: Network Management and Provider Operations

Martin's Point Health Care

P.O. Box 9746

Portland, ME 04104-5040

Questions? Please call the Network Management and Provider Operations staff at 1-800-348-9804, option 4.

