Provider Demographic Change Request

GENERAL INFORMATION		
NAME OF REQUESTOR:		
DATE OF REQUEST:		
HEALTH PLAN NAME:	**Coordinated Care**	
PROGRAM NAME (IF APPLICABLE):		
CHANGE FOR:	☐ **PROVIDER** ☐ **PRACTITIONER**	
	☐ **CHECK IF ROSTER IS ATTACHED**	
PROV/PRAC NAME:		
PROV/PRAC TIN:		
PROV/PRAC NPI:		
TYPE OF REQUEST:	☐ **ADD** ☐ **CHANGE** ☐ **TERM**	(For Adds, attach roster and/or CAQH data forms/For Terms attach letter on letterhead)
Effective Date:		
UPDATE TO: (Must attach documentation from Provider/Practitioner)		
PRACTITIONER/PROVIDER NAME CHANGE:		
☐ **TIN**	**NEW TIN #:**	(must include W-9)
☐ **NPI**	**NEW NPI #:**	
☐ **SPECIALTY**	**FROM** _____ **TO** _____	
OFFICE ADDRESS:	**NEW ADDRESS:**	
ADD'L ADDRESS:		
OFFICE HOURS:		
ANSWERING SVC:	**NEW #:**	
FAX #:	**NEW #:**	
OFFICE ADDRESS:	**NEW ADDRESS:**	
PHONE #:	**NEW PHONE #:**	
TERM EXISTING ADDRESS:		
BILLING ADDRESS	**NEW BILLING:**	(must include documentation from provider)
TELEPHONE # (indicate for which location)	**LOCATION** _____ **TEL #** _____	
FAX # (indicate for which location)	**LOCATION** _____ **FAX #** _____	
CHANGE IN PANEL:	**FROM** _____ **TO** _____	
ALL LOCATIONS:	☐ YES ☒ NO	
SPECIFIC LOCATIONS:		
AGE/GENDER LIMITATIONS:	**FROM** _____ **TO** _____	
ALL LOCATIONS:	☐ **YES** ☐ **NO**	
SPECIFIC LOCATION:		
DISPLAY IN DIRECTORY:	☐ **YES** ☐ **NO**	
- FOR PDM USE ONLY -		
DATE RECEIEVED BY PDM:		
ASSIGNED TO:		
CLOSED:	☒ **COMPLETE** ☒ **REJECTED**	
REJECTED REASON:		
DATE RETURNED FROM PDM:		
TAT:		

Please fax completed form to 1-877-644-4602
Coordinated Care, Attn: Contract Coordinator
or e-mail to contracting@coordinatedcarehealth.com