PRACTITIONER INFORMATION CHANGE REQUEST FORM

Instructions: Please use the form below to indicate any changes in your practice, attach any additional documentation to support the changes, and fax back to CDPHP Provider Reimbursement at (518) 641-3209.

Practitioner Information:

Practitioner Name: _____ CDPHP Prov #: _____

Name Change *(Old Name)*: _____ Individual NPI #_____

Request Termination: ☐ Request Termination of Contract

***Note**: Practitioner Signature required*

If PCP: Name of Practitioner members should be moved to:

Practice Scope: *(check all that apply)* ☐ PCP ☐ Specialist ☐ PCP & Specialist ☐ Urgent Care ☐ Hospitalist ☐ EPC

Business Relationship: *Practitioner signature required for financial changes.*

☐ Moving from one Group Practice to another Practice

☐ Tax ID # and/or Remit Address Change ***(Must Attach W-9)***

☐ Adding a new Group Practice relationship ***(Must attach W-9)***

Old Group Termination Date: _____

Name: _____

Line #1: _____

Line #2: _____

City: _____ State: _____ Zip: _____ Tax-ID #: _____

New Group: Effective Date: _____ **Remit NPI#:**_____

Name: _____

Line #1: _____

Line #2: _____

City: _____ State: _____ Zip: _____ Tax-ID #: _____

Phone # (____)_____ Fax #: (____)_____

If Mid-Level Practitioner, ***MUST*** provide name of new collaborating/ Sponsoring MD:_____

Correspondence Address ***(All Plan Correspondence will go to this address)***

Line #1: _____

Line #2: _____

City: _____ State: _____ Zip: _____

Physical Office Locations: ***Office Manager or Practitioner signature required.***

☐ Moving from one Physical Office Location to another

☐ Change in Physical Office Location Information

☐ Adding a new Physical Office Location

☐ Leaving a Physical Office Location

Current/Old Office: Termination Date: _____

Name: _____

Line #1: _____

Line #2: _____

City: _____ State: _____ Zip: _____ Phone #: _____

New Office: **Effective Date:**_____

Name: _____ **Site NPI#:** _____

Line #1: _____

Line #2: _____

City: _____ State: _____ Zip:_____ Phone: (__)_____ Fax:(___)_____

If PCP, indicate number of hours/week at this location:_____

PLEASE UPDATE CAQH WITH ALL CHANGES

Office Manager Name: _____ Signature: _____

Date: _____Phone#:_____

Practitioner Name: _____Signature: _____

Date: _____

PRACTITIONER SIGNATURE REQUIRED FOR ALL FINANCIAL CHANGES AND CONTRACT TERMINATIONS

Revised 8/14