STANDARDIZED PROVIDER INFORMATION CHANGE FORM

COMPLETE ALL APPLICABLE INFORMATION. INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.

NOT FOR NEW PROVIDERS OR CONTRACTUAL OR CREDENTIALING CHANGES.

1. INDICATE CHANGE(S) BEING SUBMITTED:** ***(Check all that apply — please include effective date for each item checked.) ****Section required.***			
	Effective date		***Effective date***
☐ Practice Information *(Complete Sections 2, 3, 6)*	_____	☐ Practice Status *(Complete Sections 2, 4, 6)*	_____
☐ Billing Information *(Complete Sections 2, 3, 6)*	_____	☐ Termination *(Complete Sections 2, 5, 6)*	_____
☐ Provider Name *(Complete Sections 2, 6)*	_____		
Indicate Documents Included: ☐ W9 ☐ Provider Roster ☐ Other _____			

PLEASE COMPLETE THE APPLICABLE SECTIONS BELOW TO UPDATE YOUR INFORMATION.
IF CHANGING TAX INFORMATION, YOU ARE REQUIRED TO SUBMIT AN UPDATED W9 WITH THIS FORM.

2. PROVIDER INFORMATION:** ****Section required.			
Provider Last Name:	First Name:	MI:	
Provider Former Name *(If Applicable)*:			
NPI#:	Medicaid ID# *(If Applicable)*:	PTAN# *(If Applicable)*:	TAX ID#:
Provider Type: ☐ PCP ☐ Specialist ☐ Both ☐ Hospitalist Only ☐ Ancillary/Allied/Mid-Level			
Practice/Business Name:			
Street:			
City:	State:	Zip:	
Phone:	Fax:		
Provider Email Address:			

IF APPLICABLE, PLEASE ATTACH A SEPARATE LIST WITH THE NAMES AND NPI NUMBERS OF ALL OF THE PROVIDERS IN THIS GROUP FOR WHOM THE ADDRESS CHANGE IS APPLICABLE.

3. ADDRESS INFORMATION:			
ENTER NEW OR ADDITIONAL ADDRESSES BELOW		**ENTER OLD ADDRESSES *TO BE TERMINATED* BELOW**	
Address Type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing		Address Type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing	
Address Line 1:	Suite #:	Address Line 1:	Suite #:
Address Line 2:		Address Line 2:	
City:		City:	
State:	Zip:	State:	Zip:
Phone:	Fax:	Phone:	Fax:
Office Hours:	Disability Access: ☐ Yes ☐ No	Office Hours:	Disability Access: ☐ Yes ☐ No
Languages Spoken by Provider or Office Staff:		Languages Spoken by Provider or Office Staff:	

Address Type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing		Address Type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing	
Address Line 1:	Suite #:	Address Line 1:	Suite #:
Address Line 2:		Address Line 2:	
City:		City:	
State:	Zip:	State:	Zip:
Phone:	Fax:	Phone:	Fax:
Office Hours:	Disability Access: ☐ Yes ☐ No	Office Hours:	Disability Access: ☐ Yes ☐ No
Languages Spoken by Provider or Office Staff:		Languages Spoken by Provider or Office Staff:	

Contact Person Completing Form:	Phone:

(continued on next page)

STANDARDIZED PROVIDER INFORMATION CHANGE FORM (*CONTINUED*)

Provider Name: _____

4. PRACTICE STATUS: *May be impacted by contract terms and follow-up may be required.*

Practitioner Availability Status:

- ☐ Accepting New Patients
- ☐ Accepting Existing Patients Only
- ☐ Closed *(Not Accepting New Patients and Not Accepting Existing Patients)*
- ☐ Concierge Practice
- ☐ Nursing Home Only
- ☐ Other *(Please Specify)* _____

Do you offer telemedicine/telehealth (i.e., video visits)? ☐ Yes ☐ No

Do you offer lactation counseling services? ☐ Yes ☐ No

5. TERMINATION: *Effective date may be impacted by contract terms and follow-up may be required.*

Reason for termination, please check only one box:

- ☐ Resigned
- ☐ Retired
- ☐ Deceased
- ☐ Leave of Absence*
- ☐ Moved Out-of-State
- ☐ Practice Closed
- ☐ Provider Sanctioned*
- ☐ Sabbatical*
- ☐ Provider Transferred To *(Group Name)* _____
- ☐ Other _____

**Please provide a separate explanation of the details to the plan (i.e., duration of absence for leave/sabbatical or sanction specifics).*

*6. CONTACT PERSON SUBMITTING INFORMATION: **Section required.*

Name:	Title:
Phone:	Fax:
Email:	
Date of Submission:	

SUBMISSION INFORMATION:

Blue Cross Blue Shield of MA Provider Enrollment Dept. PO Box 55350 Boston, MA 02205-5350 Email: provider-enrollment@bcbsma.com Fax: (617) 246-7771 Phone: (800) 316-BLUE (2583)	Fallon Health Attn: Provider Data Updates 1 Mercantile St., STE. 400 Worcester, MA 01608 Email: providerdataupdates@fallonhealth.org Fax: (508) 368-9902 Provider Services: (866) 275-3247, opt. 4	Harvard Pilgrim Health Care Attn: Provider Processing Center 1600 Crown Colony Drive Quincy, MA 02169 Email: PPC@point32health.org Fax: (866) 884-3843 Provider Service Center: (800) 708-4414
Health New England Attn: Provider Enrollment Department One Monarch Place, Suite 1500 Springfield, MA 01144 Email: penrollment@hne.com Fax: (413) 233-2665 Phone: (800) 842-4464, ext. 3344	Mass General Brigham Health Plan Attn: Claims Adjustments, Appeals, and Correspondence 399 Revolution Drive, Suite 810 Somerville, MA 02145 Fax: (617) 526-1902	Tufts Health Public Plans Provider Information Department 1 Wellness Way Canton, MA 02021 Email: provider_data_request@point32health.org Fax: (857) 304-6311
Tufts Health Plan Provider Information Department 1 Wellness Way Canton, MA 02021 Email: provider_information_dept@ point32health.org Fax: (617) 972-9044	Senior Whole Health Attn: Provider Relations 58 Charles Street Cambridge, MA 02141 Email: providerrelations@seniorwholehealth.com Fax: (617) 551-4185 Phone: (617) 494-5353	UniCare Provider Relations Department PO Box 9022 Andover, MA 01810 Email: unicareproviderrelations@wellpoint.com Fax: (978) 474-6188 Phone: (800) 480-7587
WellSense Health Plan Provider Processing Center 529 Main Street, Suite 500 Charlestown, MA 02129 Email: BMCHP.providerprocessingcenter@ bmchp.org Fax: (617) 897-0818 Provider Processing Center: (888) 566-0008		

IF APPLICABLE, SUBMIT COPY OF COMPLETED FORM TO IPA/PHO COORDINATOR OR ADMINISTRATOR.