Demographic/Directory Change Request Form

Accurate and complete information is important to keep our provider directory as accurate as possible. Please communicate all changes for new providers, terminations, office changes, or etc. When submitting changes, please ensure that all information is complete as incomplete forms will delay the processing of your request as we will be unable to process incomplete forms.

Section I Current Practice/Organization Demographics

Practice Name:	Tax ID:
Department:	Group NPI:
Address:	Remittance/Pay to address:
Tel:	Tel:
Fax:	Fax:

Office Manager Name:	Practice Phone Number:	Office Email:
Billing Contact Name:	Billing Phone Number:	Email:
Credentialing Contact Name:	Credentialing Phone Number:	Email:

Electronic Medical Record (EMR) System Used:

- ☐ PCP
- ☐ Specialists
- ☐ Facility

Hours of Operation:

Day	Open AM / PM	Close AM / PM
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

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Section II Practice/Organization Information Changes

☐ **Add new address** ☐ **Change address** ☐ **Deletion of address**

Please include *ALL* location addresses. If needed, please use another copy of this form for additional addresses.

☐ New tax ID number is: ______________________ *Effective Date of Change: ____________ (please attach a copy of the W-9)

☐ We have moved.

This new address is a: ☐ Practice Address ☐ Billing Address ☐ Both Practice & Billing Address

Practice Name:	Tax ID:
Department:	Group NPI:
Address:	Remittance/Pay to address:
Tel:	Tel:
Fax:	Fax:

Office Manager Name:	Practice Phone Number:	Office Email:
Billing Contact Name:	Billing Phone Number:	Email:
Credentialing Contact Name:	Credentialing Phone Number:	Email:

Section II Practice/Organization Information Changes

☐ **Add new provider** ☐ **Deletion of provider** *Effective Date of Change: ___________________

Provider First Name	Provider Last Name	Provider degree or role [1]	Provider NPI Number	Provider CAQH Number [2]	Medicare Number	Specialty	Language other than English	Hospital Privileges	Accepting New Patients	Deletion Reason [3]	Completed Fraud Waste & Abuse Training [4]	Share Cactus Data (please check) [5]	Which Office Location is impacted

[1] Non-physician providers will need to submit collaborative/standard of care agreement with an in-network credentialed physician along with this form

[2] Provider CAQH file must be validated and accurate within 14 calendar days of adding the above providers. Any missing/incorrect items will delay the credentialing process.

[3] Provide reason for provider deletion: (i.e Deceased; Retiring; Leave of Absence; Moving outside of service area; Moving to another practice/Resignation)

[4] Please indicate if the provider has completed Fraud, Waste and Abuse training. If the provider is exempt, please indicate it.

[5] By checking the named physician represents that (a) he/she knowingly consents to our access to and retrieval of relevant information from the CACTUS Database or such other provider directory and credentialing software in use at the PHP Hospitals; (b) for the purposes of this consent, the checkmark serves as the physician's signature, and (c) all parties acknowledge that any data accessed and/or retrieved will be treated as confidential peer review/quality assurance information as defined and protected under Ohio Revised Code sections 2305.24 and 2305.252

Please email completed form back to PHG@PremierHealth.com or fax back to (937) 641-7377

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