COMMUNITY HEALTH PLAN of Washington™

PROVIDER CHANGES FORM

Please complete the appropriate section of this form and email the completed form to:
PROVIDER.CHANGES@CHPW.ORG

Please note:

- **Incomplete information may result in a delay to processing your claims.**
- **A referral is required for all services rendered prior to a provider's effective date. Effective date will be determined during the processing of the request.**

Go GREEN! Please see our Provider Manual for more information about electronic transactions
or email EDI.Support@chpw.org

INDIVIDUAL PROVIDER ADD/CHANGE/TERM FORM

Date submitted:

Is the provider in CAQH? Type "yes" or "no."

For providers in CAQH where the information is current in CAQH and CHPW has access to download the information, only the provider name, NPI, and a brief description of the change being made needs to be submitted.

Type "yes" next to your applicable option:

	Primary care provider		**Specialist provider**	
	Hospital-based provider		**Other:**	

TYPE OF CHANGE (type "yes" next to your applicable option):

Add provider		**Change provider**	
Terminate provider		**Reason for Termination**	

PROVIDER INFORMATION:

Provider's name (last, first, middle):			
Date of Birth:		Gender:	
Degree:		Languages spoken:	
Provider's specialty:		Taxonomy:	
Areas of expertise: For Behavioral Health providers, please go to page three of this form to complete your areas of expertise. Only the first five areas of expertise will be listed in our directory.			
NPI Number:		DEA # (if applicable):	
Medicaid number:		Medicare number:	
Race/Ethnicity (See pg 3 for explanation why CHPW collects this data) choose from drop down:			
Cultural Competency Training Completed? (Yes/No):			
Cultural experience may be reported here. Example: Worked for Peace Corps in Tanzania.			

Core Provider Agreement Y/N		Core Provider NPI	
Non Billing Agreement Y/N		Non Billing NPI	

Please continue to the next page

Professional License(s) **Additional licenses can be listed in the 'Additional Information' section below* **.**

License number:	State:	Issue date:	Expiration date:

Medical Education

Medical School:	State:	Start date:	Graduation date:

Residencies

Institution:	State:	Specialty:	Completion date:

PRACTICE LOCATION INFORMATION:

Start date at location: | **Term** date at location:

For terminated practice location, transfer members to:

Please type "yes" or "no" next to each:

	Accepting new patients?		Gender Affirming care?
	Available for auto assign?		Provider delivers babies?
	Is this the Primary Address?		Children's Behavioral Health Provider?
	Float location? (Provider only works at this location to cover for other providers.)		Audio-Video Telemedicine (ex: Skype, Zoom, Virtual Clinic apps)
	Exclusively Telemedicine provider at this location?		Audio Only Telemedicine (ex: Telephone, Audio-only apps)
	Able to support electronic prescribing?		Chat based Telemedicine (ex: Instant Messaging, Text-only apps)

Age or gender limits?

Practice location name:

Check/legal name:

TIN: | Group NPI:

Physical address and clinic details

Street address:

City: | State: | ZIP code:

Phone: | Fax:

Clinic website:

Languages spoken by clinic staff:

ADA Accessibilities:

Check name and billing (pay to) address

Check name:

Street address:

City: | State: | ZIP code:

Phone: | Fax:

Clinic/Group Core Provider Agreement Y/N: | Core Provider NPI:

Clinic/Group Non Billing Agreement Y/N | Clinic Non Billing NPI:

Additional addresses can be attached, please provide above information for all additional addresses.

Current Hospital Affiliation with Admitting Privileges:

Hospital: | City, State:

Status (active, provisional, courtesy, temporary, etc.):

ADDITIONAL INFORMATION:

Comments/other.

Name of person completing this form:

Phone: | Email:

Please continue to the next page

Behavioral Health Areas of Expertise

To better serve our members and to comply with HCA directory requirements, CHPW is collecting information on behavioral health providers areas of expertise. For the provider listed on this form, please provide the areas in which the provider has extensive training / experience / expertise. Only the first five will appear in our Directory.

	Abuse		Military & Veterans
	Aggression Replacement Therapy		Minority Mental Health Specialist
	Anger		Mood Disorders
	Anxiety		Obsessive Compulsive Disorder
	Attention Deficit Disorders		Other Complex Needs
	Autism		Pain Management
	Autistic Spectrum Disorder		Parent Child Intervention Therapy
	Bipolar Disorder		Personality Disorders
	Children's Mental Health		Phobias
	Chronic Illness		Post-Partum Depression
	Cognitive Behavioral Therapy		Post-Traumatic Stress Disorder
	Compulsive Gambling		Recovery Peer Support / Peer Support Services
	Crisis Stabilization / Outreach		Schizophrenia
	Depression		Sexual Dysfunction
	Dialectical Behavioral Therapy		Sleep Disorders
	Disabilities (Visual, hearing & physical impairments, intellectual and developmental disabilities)		
	Dissociative Disorders		Transgender Health
	Eating Disorders		Trauma
	Family Planning		Traumatic Brain Injury
	Family Therapy		Addiction Medicine / Substance Abuse treatment
	Gender Dysphoria		Addiction Medicine
	Geriatric Mental Health		Alcohol and Drug Information School
	Grief		Medication Assisted Treatment / Opiate Substitution Treatment
	Hormone Replacement Therapy		Opioid Treatment
	Infertility		Pregnant, Parenting and Postpartum Women Treatment for Substance Abuse
	Learning Disabilities		
	Less Restrictive Alternative Support		Substance Use Disorder
	LGBTQIA+		Withdrawal Management

Other:

Types of Services Provided:

Race, ethnicity, and language information is collected in support of NCQA's Health Equity standards and CHPW's efforts to reduce health disparities. This information may appear in our directory. This information may not be used in any way to discriminate by the Health Plan. This information is **voluntary**.

Race / Ethnicity

Decline to Answer