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 ProviderSource? Type "yes" or "no."

For providers in ProviderSource where the information is current in ProviderSource 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 information) 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?		Available for auto assign?
	Provider delivers babies?		Children's Behavioral Health Provider?
	Telemedicine provider at this location? (Provider is at this location only via Telemedicine)		Float location? (Provider only works at this location to cover for other providers.)

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: ______

Is this the Primary Address? Type "yes" or "no." ______

****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
[ ]	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
[ ]	LGBT Issues	[ ]	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

White
Hispanic or Latino
Black or Aftrican American
Asian
American Indian or Alaska Native
Native Hawaiian or Other Pacific Islander
Other
Decline to Answer