



## PROVIDER CHANGES FORM

Please complete the appropriate section of this form and email the completed form to:

[PROVIDER.CHANGES@CHPW.ORG](mailto: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, <https://www.chpw.org/for-providers/provider-manual1/>, for more information about electronic transactions or email [EDI.Support@chpw.org](mailto: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:

<input type="checkbox"/> Primary care provider	<input type="checkbox"/> Specialist provider
<input type="checkbox"/> Hospital-based provider	<input type="checkbox"/> Other: <input style="width: 100px;" type="text"/>

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

<input type="checkbox"/> Add provider	<input type="checkbox"/> Change provider
<input type="checkbox"/> Terminate provider	<input type="checkbox"/> Reason for Termination <input style="width: 150px;" type="text"/>

#### PROVIDER INFORMATION:

<b>Provider's name (last, first, middle):</b> <input style="width: 90%;" type="text"/>			
Date of Birth:	<input style="width: 90%;" type="text"/>	Gender:	<input style="width: 90%;" type="text"/>
Degree:	<input style="width: 90%;" type="text"/>	Languages spoken:	<input style="width: 90%;" type="text"/>
Provider's specialty:	<input style="width: 95%;" type="text"/>		
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:	<input style="width: 90%;" type="text"/>	DEA # (if applicable):	<input style="width: 90%;" type="text"/>
Medicaid number:	<input style="width: 90%;" type="text"/>	Medicare number:	<input style="width: 90%;" type="text"/>
Race/Ethnicity (See pg 3 for explanation why CHPW collects this information) choose from drop down: <input style="width: 90%;" type="text"/>			
Cultural Competence Training Completed? (Yes/No): <input style="width: 90%;" type="text"/>			
Cultural experience may be reported here. Example: Worked for Peace Corps in Tanzania.  <input style="width: 95%; height: 40px;" type="text"/>			

Please continue to the next page

Core Provider Agreement Y/N		Core Provider NPI	
Non Billing Agreement Y/N		Non Billing NPI	
<b>Professional License(s):</b>			
License number:	State:	Issue date:	Expiration 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:**

<input type="text"/>	Accepting new patients?	<input type="text"/>	Available for auto assign?
<input type="text"/>	Provider delivers babies?	<input type="text"/>	Children's Behavioral Health Provider?
<input type="text"/>	Telemedicine provider at this location? (Provider is at this location only via Telemedicine)	<input type="text"/>	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.

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

Other:

Race, ethnicity, and language information is collected in support of NCQA's Multicultural Health Care 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 and Ethnicity	
	White	
	Hispanic or Latino	
	Black or African American	
	Asian	
	American Indian or Alaska Native	
	Native Hawaiian or Other Pacific Islander	
	Other	
	Decline to Answer	