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)*		❑ Panel 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.

2. PROVIDER INFORMATION:** ****Section required.

Provider Last Name:	First Name:	MI:
Provider Former Name *(if applicable)*		
NPI#	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:		Address line 1	
Address line 2:		Address line 2	
City		City	
State	Zip	State	Zip
Phone	Fax:	Phone	Fax:

Address type ❑ Primary ❑ Secondry ❑ Billing ❑ Mailing		Address type ❑ Primary ❑ Secondary ❑ Billing ❑ Mailing	
Address line 1:		Address line 1	
Address line 2		Address line 2	
City		City	
State	Zip	State	Zip
Phone	Fax:	Phone:	Fax:

Contact person completing form:_____ Phone:_____

(continued on next page)

STANDARDIZED PROVIDER INFORMATION CHANGE FORM (*CONTINUED*)

Provider Name: _____

4. PRIMARY CARE PANEL STATUS: *May be impacted by contract terms and follow-up may be required.*	
☐ Open panel	☐ Concierge practice
☐ Close panel	☐ Nursing home only
☐ Accepting existing patients only	☐ Other *(please specify)* _____

5. TERMINATION: *Effective date may be impactedby contract terms and follow-up may be required.*	
Reason for termination, please check only one box:	
☐ Resigned	☐ Practice closed
☐ Retired	☐ Provider sanctioned*
☐ Deceased	☐ Sabbatical*
☐ Leave of absence*	☐ Provider transferred to *(group name)* _____
☐ Moved out-of-state	☐ 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:

Fallon Health Weinberg
Provider Relations
10 Chestnut St.
Worcester, MA 01608
Fax: 716-810-1903
Phone: 1-855-827-2003