CLEAR FORM

STANDARDIZED 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
☐ Practice Information *(Complete Sections 2, 3, 6)* _____	☐ Practice 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.
IF CHANGING TAX INFORMATION, YOU ARE REQUIRED TO SUBMIT AN UPDATED W9 WITH THIS FORM.

2. PROVIDER INFORMATION:** ****Section required.			
Provider Last Name:		First Name:	MI:
Provider Former Name *(If Applicable)*:			
NPI#:	Medicaid ID# *(If Applicable)*:	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:	Suite #:	Address Line 1:	Suite #:
Address Line 2:		Address Line 2:	
City:		City:	
State:	Zip:	State:	Zip:
Phone:	Fax:	Phone:	Fax:
Office Hours:	Disability Access: ☐ Yes ☐ No	Office Hours:	Disability Access: ☐ Yes ☐ No
Languages Spoken by Provider or Office Staff:		Languages Spoken by Provider or Office Staff:	

Address Type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing		Address Type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing	
Address Line 1:	Suite #:	Address Line 1:	Suite #:
Address Line 2:		Address Line 2:	
City:		City:	
State:	Zip:	State:	Zip:
Phone:	Fax:	Phone:	Fax:
Office Hours:	Disability Access: ☐ Yes ☐ No	Office Hours:	Disability Access: ☐ Yes ☐ No
Languages Spoken by Provider or Office Staff:		Languages Spoken by Provider or Office Staff:	

Contact Person Completing Form:	Phone:

(continued on next page)

STANDARDIZED PROVIDER INFORMATION CHANGE FORM (*CONTINUED*)

Provider Name: _____

4. PRACTICE STATUS: ***May be impacted by contract terms and follow-up may be required.***

Practitioner Availability Status:

☐ Accepting New Patients
☐ Accepting Existing Patients Only
☐ Closed *(Not Accepting New Patients and Not Accepting Existing Patients)*
☐ Concierge Practice
☐ Nursing Home Only
☐ Other *(Please Specify)* _____

Do you offer telemedicine/telehealth (i.e., video visits)? ☐ Yes ☐ No

Do you offer lactation counseling services? ☐ Yes ☐ No

5. TERMINATION: ***Effective date may be impacted by contract terms and follow-up may be required.***

Reason for termination, please check only one box:

☐ Resigned
☐ Retired
☐ Deceased
☐ Leave of Absence*
☐ Moved Out-of-State
☐ Practice Closed
☐ Provider Sanctioned*
☐ Sabbatical*
☐ Provider Transferred To *(Group Name)* _____
☐ 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:

Mail:
Fallon Health Weinberg
Provider Relations
1 Mercantile St., Ste. 400
Worcester, MA 01608

Email:
AskFHW@fallonweinberg.org

Fax:
1-508-368-9902

Phone:
1-855-827-2003