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		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:		Address line 1:	
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:		Address line 1:	
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:

Blue Cross Blue Shield of MA Provider Enrollment Dept. PO Box 55350 Boston, MA 02205-5350 Email: provider-enrollment@bcbsma.com Fax: (617) 246-7771 Phone: (800) 316-BLUE (2583)	Boston Medical Center HealthNet Plan Provider Processing Center 529 Main Street, Suite 500 Charlestown, MA 02129 Email: BMCHP.providerprocessingcenter@bmchp.org Fax: (617) 897-0818 Provider Processing Center: (888) 566-0008	CeltiCare Health Plan of Massachusetts Attn: Provider Services 200 West Street, Suite 250 Waltham, MA 02451 Email: providerupdatesma@centene.com Fax: (855) 266-4991 Phone: (866) 895-1786
Fallon Health One Chestnut Place 10 Chestnut Street Worcester, MA 01608 Email: askfchp@fchp.org Fax: (508) 368-9902 Provider Services: (866) 275-3247, Opt. 4	Harvard Pilgrim Health Care Attn: Provider Processing Center 1600 Crown Colony Drive, 2nd Floor Quincy, MA 02169 Email: PPC@harvardpilgrim.org Fax: (866) 884-3843 Provider Service Center: (800) 708-4414	Health New England Attn: Provider Enrollment Department One Monarch Place, Suite 1500 Springfield, MA 01144 Email: penrollment@hne.com Fax: (413) 233-2665 Phone: (800) 842-4464, ext. 3344
Neighborhood Health Plan Credentialing Department 399 Revolution Drive, Suite 940 Somerville, MA 02145 Email: pec@nhp.org Fax: (617) 526-1982 Provider Services: (855) 444-4647	Tufts Health Public Plans Provider Information Department 705 Mount Auburn Street Watertown, MA 02472 Fax: (857) 304-6311 Email: Provider_data_request@tufts-health.com	Tufts Health Plan Provider Information Department 705 Mount Auburn Street Watertown, MA 02472 Fax: (617) 972-9044 Email: Provider_Information_Dept@ tufts-health.com
Senior Whole Health Attn: Provider Relations 58 Charles Street Cambridge, MA 02141 Email: providerrelations@seniorwholehealth.com Fax: (617) 551-4185 Phone: (617) 494-5353	UniCare Provider Relations Department PO Box 9022 Andover, MA 01810 Email: unicareproviderrelations@wellpoint.com Fax: (978) 474-6188 Phone: (800) 480-7587	

IF APPLICABLE, SUBMIT COPY OF COMPLETED FORM TO IPA/PHO COORDINATOR OR ADMINISTRATOR.