Physicians Health Plan

PHP MEDICARE

Provider Information Update Form

Please click on the following applicable item to be taken to that section within the form:

* Provider Name Change

* Tax ID Change

* Change Opening/Closing to new Patients Status

* Practice Move/Address Change

* Adding an Additional Address

* Billing/Remittance Address Change

* Update Facility/Group Services

* Update Behavioral Health Providers Areas of Interest

* Provider Leaving Practice/Location

* Location Closing

*Update Telehealth Services Provided

* Other Information Update

In addition to the applicable section above, please complete the attestation on the last page of this form. All provider information updates must be reflected in NPPES NPI Registry prior to PHP changes may be completed.

Return completed form to:

Physicians Health Plan

Attn: Network Services

PO Box 30377 Lansing MI 48909

Fax: 517.364.8412 or Email: PHPProviderUpdates@phpmm.org

If you have any questions, please call 517.364.8312 and press option 1

Date of Request:

Section I: Provider Name Change

(Please note: State License must be updated prior to submitting a name change request)

Previous Name:

New Name:

Michigan State License #:

Section II: Tax ID Change

Previous Tax ID:

Date new Tax ID is taking effect:

The new Tax ID number is:

(Please attach an updated W9 with this request)

Section III: Change Opening/Closing to new Patients Status

(If all individual practitioners at the location should be updated, complete the following section with the group/practice information)

Provider Name:

Provider NPI: Tax ID:

Practice Address Check box if all addresses are affected by this change

Number and Street City State Zip Code

Phone #: Fax #:

Closing to new Patients: Commercial Medicare

Opening to new Patients: Commercial Medicare

Effective Date:

Date of Request:

Section IV: Practice Move/Address Change

If address change affects multiple practitioners, please complete the below information for the group/practice.

Data required to match NPPES NPI Registry prior to update. See end of form for NPPES details.

Provider Name: Provider NPI:

Group Name (DBA): Group NPI:

Date new address is effective: Tax ID:

Previous Address:

Number and Street City State Zip Code

Phone #: Fax #:

New Address:

Number and Street City State Zip Code

Phone #: Fax #: Email:

Billing/Remittance Address (Check box if same as new practice address above)

Number and Street City State Zip Code

Phone #: Fax #: Email:

Correspondence/Mailing Address (Check box if same as new practice address above)

Number and Street City State Zip Code

Phone #: Fax #:

Medical Records Address (Check box if same as new practice address above)

Number and Street City State Zip Code

Phone #: Fax #: Email:

Accepting new Patients: Commercial Medicare

Not Accepting new Patients: Commercial Medicare

Telehealth Services Provided: Yes No

(if yes, Provider must complete attestation in Section XI)

Date of Request:

Can patients schedule appointments with provider at this location? Yes No

Office Hours: (Please include A.M./P.M. designation)

24 Hour Facility

Monday:	Open	Close
Tuesday:	Open	Close
Wednesday:	Open	Close
Thursday:	Open	Close
Friday:	Open	Close
Saturday:	Open	Close
Sunday:	Open	Close

Section V: Adding an Additional Address

Please note: If adding an additional address to multiple practitioners, please complete the below information for the group and **attach a roster of practitioner names and NPI numbers** to be added to the additional address below.

Data required to match NPPES NPI Registry prior to update. See end of form for NPPES details.

Provider Name: Provider NPI:

Group Name (DBA): Group NPI:

Date this address is effective: Tax ID:

New Address:

Number and Street City State Zip Code

Phone #: Fax #: Email:

Billing/Remittance Address (Check box if same as new practice address above)

Number and Street City State Zip Code

Phone #: Fax #: Email:

Correspondence/Mailing Address (Check box if same as new practice address above)

Number and Street City State Zip Code

Phone #: Fax #:

Date of Request:

Medical Records Address (Check box if same as new practice address above)

Number and Street	City	State	Zip Code

Phone #: Fax #: Email:

Accepting new Patients: Commercial Medicare

Not Accepting new Patients: Commercial Medicare

Telehealth Services Provided: Yes No

(if yes, Provider must complete attestation in Section XI)

Can patients schedule appointments with provider at this location? Yes No

Office Hours: (Please include A.M./P.M. designation)

24 Hour Facility

Monday: Open Close

Tuesday: Open Close

Wednesday: Open Close

Thursday: Open Close

Friday: Open Close

Saturday: Open Close

Sunday: Open Close

Date of Request:

Section VI: Billing/Remittance Address Change

Facility/Practice Name:

Facility/Practice NPI: Tax ID:

Date this new address is effective:

Previous Billing/Remittance Address:

Number and Street	City	State	Zip Code

Phone #: Fax #:

New Billing/Remittance Address:

Number and Street	City	State	Zip Code

Phone #: Fax #: Email:

Please complete the following to ensure our records are accurate:

Practice Address (Check box if same as new billing address above)

Number and Street	City	State	Zip Code

Phone #: Fax #: Email:

Correspondence/Mailing Address (Check box if same as new billing address above)

Number and Street	City	State	Zip Code

Phone #: Fax #:

Medical Records Address (Check box if same as new billing address above)

Number and Street	City	State	Zip Code

Phone #: Fax #: Email:

Date of Request:

Section VII: Update Facility/Group Services

Provider Name:

Provider NPI: Tax ID:

Practice Address ____

Number and Street City State Zip Code

Phone #: Fax #:

Check the boxes for **ALL** services/programs the location has available to patients and complete any appropriate responses related to the services listed.

Acute Inpatient Care

Number of Beds _____

Cardiac Surgery Program

Cardiac Catheterization Services

Critical Care Services/Intensive Care Units (ICU)

Number of Beds_____

Diagnostic Radiology

X-Ray

MRI

CT Scan

PET Scan

Laboratory Services

Hospital Med/Surgical

Number of Beds_____

Hospital OB

Number of Beds_____

Hospital Pediatric

Number of Beds_____

Inpatient Psychiatric Facility

Number of Beds_____

Sleep Lab

Number of Beds_____

Outpatient Substance Abuse

Inpatient Substance Abuse

Outpatient Behavioral Health

Outpatient Dialysis

Physical Therapy

Occupational Therapy

Speech Therapy

Nuclear Cardiology

Surgical Services (Outpatient or ASC)

Skilled Nursing Facilities

Number of Beds_____

Inpatient Psychiatric Facility Services

Number of Beds_____

Orthotics and Prosthetics

Home Health

Durable Medical Equipment

Outpatient Infusion/Chemotherapy

Transplant Program

(Identify the types of transplants below)

Heart Heart/Lung Kidney

Liver Lung Pancreas

Other Services

Date of Request:

Section VIII: Update Behavioral Health Providers Areas of Interest

(**Provider** must review and sign attestation within this section. Please note, for this section, the attestation on the last page of this form is not required)

To designate an area of interest/specialty to be included in PHPs provider directory you must sign the Behavioral Health Area of Interest/Specialty Attestation and indicate the area of interest.

This attestation serves as documentation that you have completed any additional training, experience, agency or state approval, as may be required for populations, professional certifications, specialties or areas of interest listed below. By signing this attestation, you are attesting that all required educations, trainings, certifications, State or agency approvals have been completed to be designated with the area of interest/specialty marked.

__ Ages 0-3 years

__ Ages 0-5 years

__ Ages 6-12 years

__ Ages (Adolescents) 13-18 years

__Geriatrics

__Addiction Disorders

__Anxiety Disorders

__Autism Spectrum Disorders (ASD)

__Chemical Dependency/Substance Abuse

__Critical Incident Stress Debriefing (CISD)

__Chronic Pain

__ Depression

__Eating Disorders

__Grief

__Neuropsychological Testing

__Suboxone Treatment

__Telehealth

Also provide in office services:

___ Yes ___No

__ Other (Please list)

____

____

I understand that it is my responsibility to ensure all required education, training, certifications, agency or state approvals are completed prior to being designated in this area of interest/specialty I have designated above.

I attest, that any telehealth services are provided via a HIPAA complaint interactive audio and/or video telecommunications system with provisions for the patient's privacy and security. The system is a multi-media communication that, at a minimum, includes audio equipment permitting real-time consultation.

I hereby attest that all of the information above is true and accurate. I understand that information noted in this attestation that is subsequently found to be untrue and/or incorrect could result in my termination from the PHP Provider Network.

Printed Name of Behavioral Health Specialist____

Signature of Behavioral Health Specialist _______________________________________ Date ___________

Date of Request:

Section IX: Provider Leaving Practice/Location

Provider Name:

Provider's Individual NPI (Type I):

Provider's last day at this location:

Reason for leaving:

Check box if leaving all locations for organization, otherwise indicate location below

Location provider is leaving:

Group Name:

Group NPI:

Address provider is leaving:

Number and Street City State Zip Code

Phone #:

Tax ID:

For PCP's, please provide the name of the practitioner(s) for member reassignment:

Is Provider still practicing in the PHP service area for a different organization? Yes No

If yes, please provide location information (if known):

Practice Name:

Number and Street City State Zip Code

Phone #:

Section X: Location Closing

Facility/Practice Name:

Group NPI (Type II):

Date Location is Closing:

Location address that is closing:

Number and Street City State Zip Code

Phone #:

Tax ID:

Practitioners practicing at this location are:

Leaving organization when location closes

Transferring/providing services at another location within the organization

Date of Request:

If Transferring to another location complete roster below:

(if more space is needed, attach a roster in the following format)

Practitioner Name	Title	Practitioner NPI	Address/Location Transferring To

Section XI: Update Telehealth Services Provided

(**Provider** must review and sign attestation within this section. Please note, for this section, the attestation on the last page of this form is not required)

To be included in PHPs provider directory as a Telehealth provider, you must sign the Telehealth Attestation and indicate the type of services you provide. By signing this attestation, you are attesting that all required educations, trainings, certifications, State or agency approvals have been completed to be designated as a Telehealth provider and you have a HIPAA compliant, multi-media telecommunications system.

___I no longer provide telehealth services

___I provide telehealth services only (I do not provide services in an office setting)

___I provide services in both a telehealth and office setting

I understand that it is my responsibility to ensure all required education, training, certifications, agency or state approvals are completed prior to being designated as a telehealth provider.

I attest, that any telehealth services are provided via a HIPAA complaint interactive audio and/or video telecommunications system with provisions for the patient's privacy and security. The system is a multi-media communication that, at a minimum, includes audio equipment permitting real-time consultation.

I hereby attest that all of the information above is true and accurate. I understand that information noted in this attestation that is subsequently found to be untrue and/or incorrect could result in my termination from the PHP Provider Network.

Printed Name of Provider____

Signature of Provider _______________________________________ Date ___________

Date of Request:

Section XII: Other Information Update

(Please describe below the update that is needed)

NPPES NPI Registry

To view current NPPES NPI Registry, please visit the following website: https://npiregistry.cms.hhs.gov/

PHP requires that provider information matches NPPES data. Additional information on how to update NPPES information can be found on the NPPES site at nppes.cms.hhs.gov/IAWeb/login.do

Attestation and Signature

I hereby certify that the above information is accurate, complete and true. I understand the information included in this form will be kept confidential and will only be used within Physicians Health Plan. I understand that any information submitted on or with this form which is found to be false or intentionally misleading may result in termination with Physicians Health Plan. I attest that I am authorized to make the above changes on behalf of my organization.

Type Name of Individual Completing this form:

Contact Phone: Contact Email:

Signature:

Date: