Practitioner/Practice Change Form

Practitioner/Group Name____

NPI#_________________________ **CAQH#**_________________________

Please add Practitioner and/or Group Name, NPI # and CAQH # on the above lines. Only complete the appropriate change type requested. NOT ALL SECTIONS NEED TO BE COMPLETED. Fax/email this form and any required documentation to each of the health plans you are contracted with.

Request Type: (Must Complete)	☐ Service Address ☐ Termination ☐ Name Change ☐ Billing Contact ☐ Billing Name/Address ☐ Credentialing Contact ☐ Specialty ☐ Practitioner Type ☐ Panel Change ☐ Other (AHCCCS Reg #, NPI# etc)

Practitioner/Group Information: (Must Complete)	Practitioner's Name:		Group Name:
	Practitioner's NPI#	**CAQH #**	Practitioner's AHCCCS#
	Group Federal Tax ID#		Group NPI#

Service Address Change:

Is this a:

☐ **Primary location**

☐ **Secondary location**

☐ **Covering location**

Address 1	☐ **Add**	☐ **Delete**	**EFFECTIVE DATE:**
Street:		Suite #:	
City:	State:	Zip Code:	
Appointment Telephone:	Fax:	Email:	

Office Hours:	**Day**	**Open**	**Closed**	**Day**	**Open**	**Closed**	**Special Considerations: (i.e., closed for lunch, etc)**
	Mon			Fri			
	Tues			Sat			
	Wed			Sun			
	Thurs						

List Practitioner in Directories at this address: ☐ Yes ☐ No

Location NPI: | Handicap accessible ☐ Yes ☐ NO

Address 2	☐ **Add**	☐ **Delete**	**EFFECTIVE DATE:**
Street:		Suite #:	
City:	State:	Zip Code:	
Appointment Telephone:	Fax:	Email:	

Office Hours:	**Day**	**Open**	**Closed**	**Day**	**Open**	**Closed**	**Special Considerations: (i.e., closed for lunch, etc)**
	Mon			Fri			
	Tues			Sat			
	Wed			Sun			
	Thurs						

List Practitioner in Directories at this address: ☐ Yes ☐ No

Location NPI:

INTERNAL USE ONLY:

Site visit required

☐ YES

☐ NO

Practitioner/Practice Change Form

Practitioner/Group Name____

NPI#___________________________ **CAQH#**___________________________

Practitioner Termination Request: (Practitioner is leaving the practice/group for any reason)	PCP Member Reassignment? ☐ Yes ☐ No	Effective Date of Term:
	Reassigned Practitioner Name:	Reassigned Practitioner NPI:
	Reason for Term: ☐ Leaving practice/group ☐ Retired ☐ Death ☐ Other (Explain):	

Practitioner Location Change: (Practitioner is remaining with the practice but changing locations)	PCP Member Reassignment? (Will members remain at previous location?) ☐ Yes ☐ No	Effective Date of Change to New Location:
	Reassigned Practitioner Name :	Reassigned Practitioner NPI:

Practitioner Name Change:	Previous Last, First, and Middle Name:	New Last, First, and Middle Name:
	Effective Date:	
Required Documentation	*For any name changes, a copy of Practitioner's current license reflecting the change is required to be submitted with this form and/or AHCCCS Registration, NPI #*	

Billing/Remit Address:	Legal Name:		Previous Legal name
	Street:		Suite #:
	City:	State:	Zip Code:
	Telephone:	Fax:	Email:
	Effective Date:		
Required Documentation	*A W 9 must be submitted*		

Billing Contact Change:	Name:		Title:
	Street:		Suite #:
	City:	State:	Zip Code:
	Telephone:	Fax:	Email:
	Effective Date:		

Practitioner/Practice Change Form

Practitioner/Group Name____

NPI#_________________________ **CAQH#**_________________________

Credentialing Contact Change	Name:		Title:
	Street:		Suite #:
	City:	State:	Zip Code:
	Telephone:	Fax:	Email:
	Effective Date:		

Practitioner Specialty or Provider Type Change:	Previous Practitioner Specialty/Provider Type:	
	New Practitioner Specialty/Provider Type:	Effective Date:
Required Documentation	***Any change in this section may require a credentialing event. If changing your NPI# and/or AHCCCS Registration you MUST complete the Practitioner or Organizational/Facility Application as appropriate.*** *Please confirm with your Practitioner Rep at the health plans for what is required.* *For any change in Specialty, documentation that supports the change in specialty needs to be submitted with this form, i.e., education, certification, etc. update with AHCCCS prior to submitting,*	

Panel Change: (Complete for any change to panel—open and closed, number of members assigned, change in ages of members with effective date of change)	Panel ☐ OPEN ☐ CLOSE ☐ MAX PANEL LIMIT ☐ AGES
	If change in max panel limit or age range of member, please provide an explanation:
	Effective Date:

Practitioner/Practice Change Form

Practitioner/Group Name____

NPI#__________________________ **CAQH#**__________________________

Other Changes (any other change being requested)	☐ AHCCCS Registration # ☐ NPI# ☐ DEA # ☐ TIN # ☐ Other (Describe i.e., change in languages spoken, hospital privileges etc.):	
	Previous #	Current #
	Effective Date:	

Request Submitted by	Name:	Title:
	Date:	
	Phone:	Email:

Practitioner/Practice Change Form

Practitioner/Group Name____

NPI#____________________________ **CAQH#**____________________________