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.

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

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:

Section IV: Practice Move/Address Change

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

Provider Name:

Provider NPI: Tax ID:

Date this new address is effective:

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)

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)

Provider Name:

Provider NPI: Tax ID:

Date this address is effective:

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)

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 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:

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

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 _____

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:

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

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 _____

Section XII: Other Information Update

(Please describe below the update that is needed)

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: