Physicians Health Plan Demographic/Practice Information Update Form

Provider Name _____

Current Provider/Practice TIN: _____

Practice Name _____

Name of Individual Completing this form _____

Contact Phone _____

Please make the following changes to our demographic/practice information:

☐ The new tax id number is: _____

Legal name corresponding to tax id number: _____

☐ Type of form used for billing: ☐ CMS-1500 ☐ UB-04

☐ We have moved/Address changed. This new address is effective, _____

New Address:
(Please include phone and fax numbers)

_____

_____

_____

_____

Previous Address:

_____

_____

_____

_____

☐ We have added an additional address.

Additional Address:
(Please include phone and fax numbers)

_____

_____

_____

_____

☐ We are accepting new Commercial patients at the above address, effective: _____

☐ We are accepting new Medicaid patients at the above address, effective: _____

☐ We are a CSHCS provider and accepting new patients

☐ Office hours associated with the above change: _____

☐ We have changed our billing address. The new address is effective, _____

New Billing Address:
(Please include phone and fax numbers)

_____

_____

_____

_____

Previous Billing Address:

_____

_____

_____

_____

Please continue to page 2.

☐ We have added _____to our practice, effective _____.

Please send a contract, Physician/Provider Application Form and other required credentialing forms.
Note: Physician/Provider Application Form may be downloaded from the PHP website at www.phpmichigan.com

The physician/provider, _____has left our practice.

Effective _____. Reason:_____

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

_____

☐ We are closing our practice to new Commercial patients, effective: _____

☐ We are closing our practice to new Medicaid patients, effective: _____

☐ We are opening our practice to new Commercial patients, effective: _____

☐ We are opening our practice to new Medicaid patients, effective: _____

Return completed form to: Physicians Health Plan
Attn: Network Services, PO Box 30377, Lansing, MI 48909 or fax to 517.364.8412 or by email to: php.credentialing@phpmm.org

Signature of Participating Physician/Provider/Representative _____

Printed or typed name: _____