PROVIDER CHANGE FORM

Use this form for changes to existing provider information.

Note: If you are part of a physician organization/physician hospital organization, do not send form directly to HAP. All changes must be submitted from your PO/PHO organization.

Instructions

1. This form is a fillable PDF. Please **download** it and complete the fields.

2. Check the appropriate box for type of change. Then refer to sections that need to be completed.

X	For	Complete Sections
	Add new practice locations	1, 8
	Billing (pay to) address change (only one pay to address per Tax ID allowed)	1, 2
	Leaving HAP and/or HAP Empowered	1, 6
	Office address/phone/fax changes	1, 4
	Patient accepting status	1, 5
	Provider type change (e.g., PCP to Specialist, etc.)	1, 5
	Specialty type change or addition	1, 5
	Tax ID (TIN) changes	1, 3
	Transferring networks (physicians)	1, 7
	Other (for information related to demographic updates, terminations, or transfers)	1, 9

3. All changes require 30-day notice to HAP.

4. We will only accept current W-9 forms (nothing older than 10 years). **Be sure to sign and date the form. Forms are considered incomplete if not signed and dated.**

5. **Email completed Provider Change Form and current, signed and dated W-9 to providernetwork@hap.org. Be sure to put "Provider Change Form" in subject line. Incomplete forms and incomplete W-9's may be returned.**

IMPORTANT!
Be sure your data in the National Plan & Provider Enumeration System (NPPES) is accurate! To verify your information, log in at the NPPES website. When reviewing, pay close attention to:

- Provider name
- Mailing address
- Telephone and fax numbers
- Specialty
- Taxonomy
- Practice locations no longer use

Section 1
Must be completed by all providers – all fields required

PROVIDER INFORMATION					
Provider full name:				Degree:	
Practice name (if applicable):					
NPI Type 1 (individual):		NPI Type 2 (group):		Tax ID:	
Network (physician hospital organization): (if applicable)					
Specialty/Service:					

CONTACT INFORMATION (PERSON SUBMITTING FORM)			
First & last name:			
Title:			
Contact phone:		Contact fax:	
Contact email:			

Section 2
Billing (Pay To) Address Change

Update billing (pay to) address for Tax ID (TIN):

Street:

City, ST, zip:

Phone: Fax:

Email:

Effective date of change:

Note: Only one pay to address per Tax ID allowed. Be sure to submit current W-9. It must be signed and dated.

Section 3
Tax ID (TIN) Changes

Delete TIN(s):

Add TIN(s):

Be sure to submit a current W-9 for each TIN being added. It must be signed and dated.

Section 4
Office Address Changes

CURRENT	CHANGE REQUESTED
TIN: Street: City, ST, Zip: Phone: Fax: Email: Is this your primary address? ☐ Yes ☐ No	☐ **Delete address** ☐ **Update address to:** TIN: Street: City, ST, Zip: Phone: Fax: Email: Website: Telehealth services offered? ☐ Yes ☐ No Hours: M: T: W: Th: F: S: S: Effective date of change:
TIN: Street: City, ST, Zip: Phone: Fax: Email: Is this your primary address? ☐ Yes ☐ No	☐ **Delete address** ☐ **Update address to:** TIN: Street: City, ST, Zip: Phone: Fax: Email: Website: Telehealth services offered? ☐ Yes ☐ No Hours: M: T: W: Th: F: S: S: Effective date of change:

Note: To add new office locations or to make changes to other existing addresses, complete section 8.

Section 5
Practice Information

PATIENT ACCEPTING STATUS
☐ Close panel to new patients Effective date: ☐ Open panel to new patients Effective date: Comments:

PROVIDER TYPE OR SPECIALTY CHANGE/ADDITION
☐ PCP changing to Specialist ☐ Specialist changing to PCP ☐ Specialty change From: To: ☐ Adding specialty: Note: Credentialing may be required for any of these changes.

Section 6
Leaving HAP & HAP Empowered

Reason for leaving:

☐ Deceased ☐ Contract Termination ☐ Moving out of service area

☐ Moving out of state ☐ Resigned ☐ Retiring

☐ Leave of absence (dates):

Effective date:

If PCP, move membership to:

Physician name: NPI:

Note: Depending on your contract arrangement, membership may be assigned to another PCP in your physician organization. Members can only be assigned to one PCP. You cannot divide among physicians.

Section 7
Physician Transferring Networks

PRIMARY CARE PHYSICIAN TRANSFERRING NETWORKS

Note: If you are part of a physician organization/physician hospital organization, do not send form directly to HAP. The PO/PHO group medical director or their designee must complete this form.

Current PHO/PO/ACO:

Move to PHO/PO/ACO:

Membership transferring to new physician?

☐ **Yes**, **transfer to**:

Physician Name: NPI:

☐ **No,** move with current PCP to new PHO/PO/ACO

Effective date:

SPECIALIST UPDATES TO NETWORKS

Remove from:

Add to:

Section 8 – Extra Page

For adding new office locations or making changes to other existing addresses

Additional office locations.

TIN: Street: City, ST, Zip: Phone: Fax: Email: Website: Telehealth services offered? ☐ Yes ☐ No Hours: M: T: W: Th: F: S: S: Effective date of addition:	TIN: Street: City, ST, Zip: Phone: Fax: Email: Website: Telehealth services offered? ☐ Yes ☐ No Hours: M: T: W: Th: F: S: S: Effective date of addition:

Changes to existing locations.

OFFICE ADDRESS INFORMATION	
CURRENT	**CHANGE REQUESTED**
TIN: Street: City, ST, Zip: Phone: Fax: Email: Is this your primary address? ☐ Yes ☐ No	☐ **Delete address** ☐ **Update address to:** TIN: Street: City, ST, Zip: Phone: Fax: Email: Website: Telehealth services offered? ☐ Yes ☐ No Hours: M: T: W: Th: F: S: S: Effective date of change:
TIN: Street: City, ST, Zip: Phone: Fax: Email: Is this your primary address? ☐ Yes ☐ No	☐ **Delete address** ☐ **Update address to:** TIN: Street: City, ST, Zip: Phone: Fax: Email: Website: Telehealth services offered? ☐ Yes ☐ No Hours: M: T: W: Th: F: S: S: Effective date of change:

Section 9
Other Information

Use this page for any other information related to demographic updates, terminations, or transfers.