Provider Change Form Instructions

Please reference the table below before completing this form. Please attach a W9 for all changes. Please use one form per change.

Facility/Provider = hospital, group, FQHC, RHC, etc.
Practitioner = MD, DO, ARNP, or other individual that works within a Facility/Provider location

EFFECTIVE DATE OF CHANGE

Changes must be received at least 30 days in advance so that the change may be made prior to a provider or practitioner seeing NH Healthy Families members.

Change Type	Documents Required? An updated W9 will be required for all.	Email
I have a Legal Business Name and/or TIN change	A change to the legal business name or a change in the TIN requires a contract amendment to the Participating Provider Agreement.	A request for an amendment to an existing agreement may be made by sending an email to: NH_Contracting@Centene.com
I wish to add, change, or remove a group NPI	New Credentialing Application is required. Facility/Provider's NPI may need to be enrolled prior to adding a service. (An email is required explaining a brief description of your intentions.)	Please complete and return all required documents in the Credentialing Application. To request a Credentialing Application, please email your request to the Contracting Department: NH_Contracting@Centene.com
I wish to add, change, or remove a current service. (ending a Service may be done without terminating the agreement) For example DME, LAB, ETC.	**To Add:** a new Credentialing Application will be required and will need to go through enrollment to determine participation with this new service under the Contract. **To Change or Remove:** Please email/ mail a formal letter on company letter head with Group name, TIN/NPI and date of change and our New Hampshire Healthy Families Contracting department will follow up if we need more details.	Please complete and return all required documents in the Credentialing Application. To request a Credentialing Application, please email your request to the Contracting Department: NH_Contracting@Centene.com
I would like to add a new practitioner / terminate a practitioner from Group/ or change a practitioner's status or address	**To Add:** a new Credentialing Application/ HCAS/ CAQH Data Form or Roster will be required; they will need to go through enrollment to determine participation with this new service under the Group Practice. **To Change:** Provider change form will be needed to change provider status (specialty/ PCP to Specialist or Panel; for example) **To Terminate:** Provider change form or a Roster for multiple terminations will be needed; when terminating a PCP please supply another PCP to move their members to.	Please submit practitioner additions or terms on the approved Health Plan roster Excel form or CAQH data form. Submit changes on the Provider change form. Send updated forms to ProviderUpdatesNH@Centene.com For **Terminations** please email: MA-NH-Terms@CENTENE.COM
I have a Practitioner with a name change	Provider Change Form **and** Legal document such as Updated NPPES and Medical License.	Please complete and email both documents to ProviderUpdatesNH@Centene.com
I wish to add/update an address – TIN is not changing	Provider Change Form For billing address changes please also submit an updated w9 and change form. Service practice location: provider change form and roster of providers working there.	Please complete one of the following: **Section A – change physical address** **Section B – change/add second address** **Section C – change billing address** **Section D – change mailing address** Then email to ProviderUpdatesNH@Centene.com
I wish to change my provider status	Provider Change Form	Please complete the following: **Section E – change of provider status** Then email to ProviderUpdatesNH@Centene.com

Provider Change Form

Please complete this section for all changes listed below:

Today's Date:	**Effective Date of Change:**
Facility or Provider Legal Name:_____	
DBA or Clinic Name (if applicable):	
TAX ID:	Medicaid#:
Group NPI#:	Taxonomy#:
Individual NPI#:	Facility Accreditation:
Licensure:	Contact Person:
State of Licensure:	Email Address:
Phone Number:	

Complete only necessary sections based on your situation.

Section A: CHANGE IN PHYSICAL ADDRESS, PHONE OR FAX

NOTE: Physical location will be included in provider directory; must be a street address (not a PO Box)

Previous Practice Location:	**New Practice Location:**
Facility/Provider Name:	Facility/Provider Name:
Address:	Address:
County:	County:
Phone #:	Phone #:
Fax:	Fax:
Contact Person:	Contact Person:
Email Address:	Email Address:
Medicaid #	Medicaid #
□ Term this Address	

Office Hours at this location? Open 24 hours - or complete hours of operations below:

MON	TUES	WED	THU	FRI	SAT	SUN

Panel Status		Languages		Hospital Affillation(s)	

Section B: Adding an ADDITIONAL PHYSICAL ADDRESS, PHONE OR FAX

If yes, contact the Contracting Department at NH_Contracting@Centene.com

Facility/Provider Name:	
Second Location Address:	
County:	
Medicaid#	
Phone #:	Fax#:
Email Address:	Contact Name:

Office Hours at this location? ☐ Open 24 hours - or complete hours of operations below:

MON	TUES	WED	THU	FRI	SAT	SUN

Panel Status		Languages		Hospital Affillation(s)	

Section C: CHANGE IN BILLING ADDRESS OR BILLING INFORMATION
Please note will also require w9.

Facility/Provider Name:	
New Billing Address:	
Phone #:	Fax #:
TAX ID#	
Exact name reported to the IRS for this Tax ID:	
Email Address:	Contact Name:

Section D: CHANGE IN MAILING ADDRESS

Facility/Provider Name:	
New Mailing Address:	
Phone #:	Fax #:
Email Address:	Contact Name:

Section E: CHANGE OF PROVIDER STATUS

Date change effective: _____

Type of change (i.e., terminating from NH Healthy Families network)

Date of Term:

Reason for Term:

PCP to Move Members to:

Section F: (Miscellaneous) CHANGE OF PROVIDER STATUS (Close or Open PCP Panel, change from PCP to SP, Update Specialty Types or Taxonomy Codes)

Date change effective: _____

Type of change: please add any updated documents that relate to the change.

_____

Explanation for the change: _____

_____

_____

_____ _____

Signature Date

I attest that this info is correct to the best of my ability. I am open to any follow up questions at: _____

Email Address