Standardized Provider Information Change Form

To ensure that our customers have the most up-to-date information for CareConnect participating providers, the Standardized Provider Information Change Form is designed for providers to submit demographic changes regarding their practice to CareConnect.

This form should be completed when changing your practice name, office address, phone numbers, fax numbers, office hours, Tax Identification Number (TIN), e-mail and billing information.

Instructions for Completing the Standardized Provider Information Change Form

Section 1: PROVIDER CONTACT INFORMATION: This section identifies the provider requesting the change.

- Provider Last Name/First Name/MI: Practitioner requesting the change
- NPI - Current individual National Practitioner Identifier (NPI)
- Tax ID - Current Tax Identification Number (TIN)
- Provider Type - Current role of the provider (PCP, Specialist, Both, etc)

Section 2: TYPE OF CHANGE: This section identifies the type of change being requested. More than one box should be checked if needed.

Section 3: DEMOGRAPHIC CHANGE (ADDS): This section identifies the new information or demographic changes. Below are the types of demographic changes for this section.

- Add/Change TIN (W-9 form needed)
- Add Service Address - Adding new service address
- Add Billing Address - Add billing address where checks and remittance is mailed
- Change Group Name - Updating the Group Practice Name (W-9 form needed)
- Add Hospital Affiliation
- Add Languages
- Add Specialty (If Board Certified, please include certification dates)

Section 4: DEMOGRAPHIC CHANGE (DELETES): This section identifies existing demographic information that needs to be terminated.

- Inactivate/Terminate TIN - Terminating an existing TIN
- Terminating Service Address - Terminating existing service address
- Terminate billing address - Terminate existing billing address where check and remittance is mailed
- Terminate Group Name – Terminate the existing Group Practice Name or affiliation

Examples:

- If changing an office and/or billing address, please complete Section 3 with new office and/or billing information and Section 4 with the office and/or billing address that needs to be terminated.
- If terminating an existing service address only, please complete Section 4.
- If changing group name, please complete Section 3 with the new group information and Section 4 with the group information that needs to be terminated.

Please complete the applicable sections below to update your information.
Please send completed form with additional documentation to ProviderUpdates@careconnect.com

SECTION 1: Provider Contact Information ***Section required.***		
Provider Last Name:	First Name:	MI:
NPI:	TIN:	
Provider Type: ☐ PCP ☐ Specialist ☐ Both ☐ Hospitalist ☐ Ancillary/Allied Health		
Contact Person Submitting Request:		
Phone:	Date of Submission:	

Please complete all applicable information below:

SECTION 2: Please indicate the type of change (Check all that apply and include effective for each item checked) ****Section Required***			
	Effective date		**Effective date**
☐ Practice Information		☐ Specialty	
☐ Billing Information (**+**)		☐ Languages	
☐ Provider/Group Name		☐ Hospital Affiliation	
☐ Panel Status			
+ Please submit a signed, dated W-9 form for all Tax Identification Number changes			

If applicable, please attach a separate list of additional locations where address update is needed.

SECTION 3: Demographic Change							
Enter new information or additional address below:							
Address Type: ☐ Office ☐ Billing				Panel Status: ☐ Open Panel ☐ Closed Panel			
Group/Practice Name:				Group NPI:			
Address Line 1:							
Address Line 2:							
City			State:		Zip Code:		
Phone:			Fax:				
Office Hours:	M:	T:	W:	TH:	FR:	SA:	SU:
Specialty:	Board Certified: ☐ Yes ☐ No		Certification Date: Certification Expiration Date:				
Languages:							
Hospital Affiliation(s):							
Wheelchair Accessible: ☐ Yes ☐ No	Email:						
TIN:	TIN Name:						

CareConnect℠

SECTION 3: Demographic Change							
Enter new information or additional address below:							
Address Type: ☐ Office ☐ Billing				Panel Status: ☐ Open Panel ☐ Closed Panel			
Group/Practice Name:					Group NPI:		
Address Line 1:							
Address Line 2:							
City				State:		Zip Code:	
Phone:				Fax:			
Office Hours:	M:	T:	W:	TH:	FR:	SA:	SU:
Specialty:		Board Certified: ☐ Yes ☐ No		Certification Date: Certification Expiration Date:			
Languages:							
Hospital Affiliation(s):							
Wheelchair Accessible: ☐ Yes ☐ No			Email:				
TIN:		TIN Name:					

If applicable, please attach a separate list or additional locations that need to be terminated.

SECTION 4: Demographic Change					
Enter old information that needs to be terminated:					
Address Type: ☐ Office ☐ Billing			TIN		
Group/Practice Name:				Group NPI:	
Address Line 1:					
Address Line 2:					
City			State:	Zip Code:	

SECTION 4: Demographic Change					
Enter old information that needs to be terminated:					
Address Type: ☐ Office ☐ Billing			TIN:		
Group/Practice Name:				Group NPI:	
Address Line 1:					
Address Line 2:					
City			State:	Zip Code:	

Please allow 30 days to process your request. Tax ID updates cannot be processed without a completed W-9. If you have any questions, please contact Customer Service at 855-706-7545 or info@careconnect.com