MEDICAL ASSOCIATES | HEALTH CHOICES | CENTRAL PLAINS PHYSICIANS HEALTH PLAN | live 360° HEALTH PLAN FEATURING HSHS NETWORK

Provider Update Form

Group Practice Information	Group Practice Name:	
	Group Practice TIN:	Group Practice NPI:
Contact Person	Credentialing Contact Name:	
	Email Address:	Phone Number:

Practitioner Information	☐Add Provider ☐Term Provider **Effective Date of Change:** _____	
Practitioner Name:		Title/Degree:
Practitioner NPI:	CAQH ID:	
Primary Practicing Specialty:	Taxonomy Code associated with NPI No.:	
Primary Practice Location:		Do you provide Telehealth services? ☐Yes ☐No
Additional Practice Locations:		Modalities Used for Telehealth ☐Video ☐Phone ☐Other _____ Services provided via Telehealth _____ Can caregivers in a separate location and with patient's consent participate in a telehealth? ☐Yes ☐No
Do you participate in Medicare: ☐Yes ☐No	Do you accept Medicare assignment? ☐Yes ☐No	Did you opt out of Medicare? ☐Yes ☐No

Location Information	☐Add Location ☐Term Location ☐Change Location **Effective Date of Change:** _____
Location to Add:	
Location to Remove:	

Demographic Change	Previous Name: _____ Effective Date: _____ New Name: _____

Please send the completed form to MAHPCredentialing@mahealthcare.com