MEDICAL ASSOCIATES | HEALTH CHOICES | CENTRAL PLAINS PHYSICIANS HEALTH PLAN

Provider Update Form

Clear Form | Submit Form

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

Practitioner Information	☐ Permanent ☐ Locum Tenen	Locum Start Date:	Locum End Date:
Practitioner Name:	Title/Degree:	☐Add Provider effective	
Practitioner NPI:	CAQH ID:	☐Term Provider effective	
Primary Practicing Specialty:	Taxonomy Code associated with NPI No.:		

Primary Practice Location Address:			☐Add Location effective ☐Term Location effective
City:	State:	Zip:	
Additional Practice Location Address:			☐Add Location effective ☐Term Location effective
City:	State:	Zip:	
Additional Practice Location Address:			☐Add Location effective ☐Term Location effective
City:	State:	Zip:	
Additional Practice Location Address:			☐Add Location effective ☐Term Location effective
City:	State:	Zip:	

Do you provide Telehealth services? ☐Yes ☐No	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

Demographic Change	Previous Name:		Effective Date:
	New Name:		