Provider and Group Information Form

Reason for Request:

- ☐ Add Primary Location
- ☐ Add Additional Location
- ☐ Change Billing/Remit Address (W9 required)
- ☐ Terminate Additional Location
- ☐ Terminate Primary Location (corresponding ADD Primary Location should be included)
- ☐ Change Mailing/Correspondence Address
- ☐ Change Point of Contact Information
- ☐ Change Panel Status (i.e. New Patients)
- ☐ Change Directory Status (i.e. Directory Print Display)

Effective Date:	PCP: ☐ Y ☐ N	Printing in Directory: ☐ Y ☐ N
First Name:	Last name:	
Middle Name:	Degree(s) (MD/DO):	Gender: ☐ M ☐ F

TIN:	NPI:	Medicare#:	CAQH#:

Type of License:	License Number:
Tax ID:	Board Certified: ☐ Y ☐ N
Specialty/Provider Type:	Taxonomy:
For Physician and Surgeons Only, please identify hospital/admitting privileges:	
Name of Group Practice/Clinic (if applicable):	
Group NPI:	Group Tax ID:
Directory Record ID (For Changes/Terminations): *(Directory Record ID found in PHP/PHC directory listing)*	

Primary Practice Location

Practice Name:		
Practice Site Street Address:		
Practice Site City:	Practice Site State:	Practice Site Zip:
Practice Site Phone:	After Hours Phone:	
Provider Office Email Address:		
Provider is Accepting New Patients at this Site: ☐ Y ☐ N		
Provider Ethnicity *(not required)*:		
Languages Spoken by Provider or Medical Interpreter at this location:		

Primary Practice Site Days & Hours when Provider Sees Patients:

Monday ☐ Yes ☐ No	Available Hours:
Tuesday ☐ Yes ☐ No	Available Hours:
Wednesday ☐ Yes ☐ No	Available Hours:
Thursday ☐ Yes ☐ No	Available Hours:

Friday ☐ Yes ☐ No	Available Hours:
Saturday ☐ Yes ☐ No	Available Hours:
Sunday ☐ Yes ☐ No	Available Hours:
Telehealth capabilities using a HIPAA compliant platform: ☐ Yes ☐ No	

Additional Practice Locations (If Any)

Secondary Practice Name:		
Secondary Practice Address:		
City:	State:	Zip:
Phone:	After Hours Phone:	
Secondary Office Email Address:		
Provider is Accepting New Patients at this Site: ☐ Y ☐ N		
Provider Ethnicity *(not required)*:		
Languages Spoken by Provider or Medical Interpreter at this location:		

Secondary Practice Site Days & Hours when Provider Sees Patients:

Monday ☐ Yes ☐ No	Available Hours:
Tuesday ☐ Yes ☐ No	Available Hours:
Wednesday ☐ Yes ☐ No	Available Hours:
Thursday ☐ Yes ☐ No	Available Hours:
Friday ☐ Yes ☐ No	Available Hours:
Saturday ☐ Yes ☐ No	Available Hours:
Sunday ☐ Yes ☐ No	Available Hours:
Telehealth capabilities using a HIPAA compliant platform: ☐ Yes ☐ No	

Billing Address (W9 is Required for Change Billing/Remit Address along with this form)

Billing Address:		
City:	State:	Zip:
Phone Number:	Fax:	
Billing Office Email Address:		

Mailing Address if different from Billing Address above

Mailing Address:		
City:	State:	Zip:

Disabled Accessibility *(check all that apply to practice site(s))*:

Primary Location	*Secondary Location (if applicable)*	
☐	☐	**Parking** - Parking spaces, including van accessible spaces(s), are accessible. Pathways have curb ramps between the parking lot, office, and at drop off locations.
☐	☐	**Exterior Building** - Curb ramps and other ramps to the building are wide enough for a wheelchair or scooter user. Handrails are provided on both sides of the ramp. There is an "accessible" entrance to the building. Doors open wide enough to let a wheelchair or scooter user enter, and have handles that are easy to use.
☐	☐	**Interior Building** - Doors open wide enough to let a wheelchair or scooter user enter, and have handles that are easy to use. Interior ramps are wide enough and have handrails. Stairs, if present, have handrails. If there is an elevator, it is available for public/patient use at all times the building is open. The elevator has easy to hear sounds and Braille buttons within reach. The elevator has enough room for a wheelchair or scooter user to turn around. If there is a platform lift, it can be used without help.
☐	☐	**Restroom** - The restroom is accessible and the doors are wide enough to accommodate a wheelchair or scooter and are easy to open. The restroom has enough room for a wheelchair or scooter to turn around and close the door. There are grab bars, which allow easy transfer from wheelchair to toilet. The sink is easy to get to and the faucets, soap, and toilet paper are easy to reach and use.
☐	☐	**Exam Room** - The entrance to the exam room is accessible, with a clear path. The doors open wide enough to accommodate a wheelchair or scooter and are easy to open. The exam room has enough room for a wheelchair or scooter to turn around.
☐	☐	**Exam Table/Scale** - The exam table moves up and down and the scale is accessible with handrails to assist people with wheelchairs and scooters. The weight scale is able to accommodate a wheelchair.

Comments:

Office Manager Contact Information:

Name: _____

Phone Number: _____

Email: _____

Contact Person filling out this form:

Name: _____

Title: _____

Phone Number: _____

Email: _____

Date: _____

I attest, by my signature that the information provided above is accurate. I attest to my understanding of the Plan's Provider Directory requirements with respect to notification to the Plans of any changes in my practice and quarterly attestation confirming the accuracy of the practice information on file with the Plans.

If any aspect of this attestation is falsified, I understand that my contract with the Plan(s) may be terminated.

Provider Signature **Date**

Provider Printed Name **E-Mail Address**

Completed Provider Update Form and W9 as applicable can be emailed to Provider Data Management at PDMdept@ahf.org.