

Provider Change/Term Form

Group Name:	TIN:
Provider Name:	Provider NPI:
Effective date of the change/term (*final effective date at health plan is dependent on contractual obligations):	
Type Of Change	
Phone Number Change Old phone number to be removed _____ Old fax number to be removed _____ ___ Primary phone number Secondary phone ___ Primary fax number Secondary fax New phone number to add _____ New fax number to add _____	
Provider name change New First Name: New Last Name:	
Change Panel Status Patient panel change-Open Patient panel change-Close *Please be aware all panels will be open or closed with all contracted payers	
Designation change (*New Designation) Primary Care Physician (PCP) Primary Care Physician / Specialists (PCP/Specialist) Specialist (SCP) *Add description	
Scope of service change: Description of services being added or removed from the practice:	

Add or Remove location

Add Location

Address Type: ___ Primary ___ Secondary ___ Billing ___ Mailing

Address line 1:

Address line 2:				
City:		State:		Zip:
Phone:		Fax:		
Remove Location				
Address Type:	Primary	Secondary	Billing	Mailing
Address line 1:				
Address line 2:				
City:		State:		Zip:
Phone:		Fax:		
*If you have additional addresses to add or remove, please attach them to a separate sheet				

TIN Change	
New TIN information: Legal Name: _____ TIN # _____	Old TIN information: Legal Name: _____ TIN # _____
Group (Type II) NPI Change	
New NPI information: NPI number _____	Old NPI information: NPI Number _____
Provider Termination Please note termination dates cannot be backdated	
Which provider in the practice will take over the patient panels of the terminated provider (PCPs only): _____ Reason for termination (please check only one box): ___ Resigned ___ Leave of absence* ___ Retired ___ Deceased ___ Provider sanctioned* ___ Sabbatical* ___ Moved out of state ___ Other <i>*Please provide a short explanation of the details for termination (e.g. duration of leave, why sanctioned, sabbatical specifics)</i> _____ _____	

Contact Person Submitting/Authorized Representative for TIN	
Name:	Signature:
Phone:	
Title:	Date of submission:
Email:	

Please send to: PLLCAdministration@bidmc.harvard.edu and ProviderChangeTerm@BIDCO.org