PhysicianPerformance
Empowering Physicians. Elevating Healthcare.

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

☐ Panel change- Existing patients only

*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):

N/A_____

Reason for termination (please check only one box):

☐ Resigned
☐ Leave of absence*
☐ Retired
☐ Deceased
☐ Provider sanctioned*
☐ Sabbatical*
☐ Moved out of state
☐ Other

**Please provide a short explanation of the details for termination(e.g. duration of leave, why sanctioned, sabbatical specifics)*

_____

_____

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