



PROVIDER CHANGE FORM

ONLY COMPLETE UPDATED INFORMATION												
Consultant Name:										Date:		
CHECK CHANGE/CORRECTION TO BE MADE BELOW:				<input type="checkbox"/> ADD		<input type="checkbox"/> CHANGE			<input type="checkbox"/> TERMINATE			
If Termination, Effective Date:			Reason:			Move Members To:						
Last Name:				First:				M.I.:		Degree:		
Name of Group:								CHN ID:				
Group Primary Address:										Unit/Floor#		
City:		State:	ZIP+4:			Gender:	M <input type="checkbox"/>	F <input type="checkbox"/>	Race/Ethnicity:			
Phone: ()					Fax: ()							
CT State Medicaid Number:			Social Security #:				Practice Tax ID:					
Group NPI #:					Group Taxonomy:							
Are you accepting new Patients?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	Are you accepting referrals for new patients?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	Do you wish to appear in provider directory?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Do you speak languages other than English?			YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so, list languages:							
Contact Full Name:					Contact Phone Number: ()							
Contact E-mail Address:					Group E-Mail Address:							
Specialties:					Provider Type:		PCP <input type="checkbox"/>		Specialist <input type="checkbox"/>		Allied Health <input type="checkbox"/>	
Individual NPI#					Individual Taxonomy#							
State license #:			Licensed State:				Expiration: ____/____/____					
DEA Certificate #:			DEA State:				Expiration: ____/____/____					
Hospital Admitting Privileges:												
ADDRESSES TO BE ADDED, CHANGED OR TERMINATED INFORMATION BELOW (EXPLAIN IN COMMENTS):												
Population Served:						Limitations/Age Restrictions:						
Billing Address:												
City/State/Zip +4:						Telephone: ()						
						Fax: ()						
Additional Practice Locations:												
Address 2:												
City/State/Zip +4:						Telephone: ()						
Wheel Chair Access:						Fax: ()						
Address 3:												
City/State/Zip +4:						Telephone: ()						
Wheel Chair Access:						Fax: ()						

OFFICE HOURS

	AM		PM		Extended Hours
	Open	Close	Open	Close	Start/End
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					

LINES OF BUSINESS: **HUSKY A:** **HUSKY B:** **CHARTER OAK:**

COMMENTS / SPECIAL DIRECTIONS (PLEASE ATTACH APPLICABLE INFORMATION, W-9, CORRESPONDENCE, ETC.):

INTERNAL USE ONLY:

Completed By:

Date:

Fax: Provider Relations Department @ (203) 265-3590
 11 Fairfield Boulevard, Wallingford, CT 06492
 Provider Call Center: (800) 440-5071 Option #7.