

# Provider Change Form



- ✓ Submit one Provider Change Form (PCF) per TIN. Do not submit changes for multiple TINs.
- ✓ The preferred method for completing the PCF is electronically. Hand written changes may result in delayed or inaccurate processing.
- ✓ Please be sure to update your CAQH application as well; your CAQH must be updated separately.
- ✓ Return PCF to [www.cenpatico.com/providers/ga/provider-tools/provider-demographic-updates](http://www.cenpatico.com/providers/ga/provider-tools/provider-demographic-updates)

What change do you need to make?	Steps to Complete:
<input type="checkbox"/> Change/add/delete primary address, email, telephone, and/or fax number	<ul style="list-style-type: none"> <li>✓ Complete SECTION A</li> <li>✓ Complete SECTION B</li> </ul>
<input type="checkbox"/> Change/add/delete secondary address, telephone, and/or fax number	<ul style="list-style-type: none"> <li>✓ Complete SECTION A</li> <li>✓ Complete SECTION B</li> </ul>
<input type="checkbox"/> Change of billing address, telephone, and or fax number	<ul style="list-style-type: none"> <li>✓ Complete SECTION A</li> <li>✓ Complete SECTION C</li> </ul>
<input type="checkbox"/> Change of mailing address, telephone, and or fax number	<ul style="list-style-type: none"> <li>✓ Complete SECTION A</li> <li>✓ Complete SECTION D</li> </ul>
<input type="checkbox"/> Change Taxonomy	<ul style="list-style-type: none"> <li>✓ Complete SECTION A</li> <li>✓ Complete SECTION E</li> </ul>
<input type="checkbox"/> Change of provider status (e.g. moved out of area, capacity changes, etc.)	<ul style="list-style-type: none"> <li>✓ Complete SECTION A</li> <li>✓ Complete SECTION F</li> </ul>
<input type="checkbox"/> Change Medicaid Number	<ul style="list-style-type: none"> <li>✓ Complete SECTION A</li> <li>✓ Complete SECTION G</li> </ul>
<input type="checkbox"/> Discontinue Behavioral Health Services	<ul style="list-style-type: none"> <li>✓ Contact your Provider Relations Rep <i>Visit <a href="http://www.pshpgeorgia.com/providers">www.pshpgeorgia.com/providers</a> to locate your Rep's contact information</i></li> </ul>
<input type="checkbox"/> Adding/changing TIN	<ul style="list-style-type: none"> <li>✓ Contact your Provider Relations Rep <i>Visit <a href="http://www.pshpgeorgia.com/providers">www.pshpgeorgia.com/providers</a> to locate your Rep's contact information</i></li> </ul>

## SECTION A REQUIRED INFORMATION

 Solo Practitioner

 Group/Clinic

Today's Date		Effective Date of Change		
Last Name	First Name	M.I.	Individual NPI	
Individual Medicaid Number	Individual Medicare Number	Phone		
Group/Clinic Name as it appears on W9 (if applicable)		TIN	Taxonomy	
Provider Email	Credentialing Contact Name	Credentialing Contact Email		

## SECTION B CHANGE IN LOCATION INFO

- Update current location     
  Add new location     
  Delete this location\*  
 This is the primary location     
  This is a secondary location     
  **DO NOT** Display in Directory

*If the Updated/New practice location below is also the Billing address please also fill out SECTION C*

NOTE: Must be a street address (not a PO Box)

Previous/Discontinued Practice Location				Updated/New Practice Location			
Group Display Name				Group Display Name			
Group NPI		Group Medicaid #		Group NPI		Group Medicaid #	
Address			Taxonomy	Address			Taxonomy
City		ST	Zip	City		ST	Zip
County	Phone		Fax	County	Phone		Fax
Contact Person				Contact Person			
Contact Email				Contact Email			

*\*Please provide a reason for deleting this location:*

- I. This location change affects:  Just the individual practitioner in SECTION A  
 All practitioners associated with this Group  
*\*Please fill out ATTACHMENT H of this form*

- II. Does this location have handicap accessibility?  Yes  No

- III. Does this location have any limitations or restrictions?

**Gender:** Male  Female   
**Age:** Beginning at:  Ending at:  All ages accepted

- IV. Please list up to two languages other than English provided at this location:

1)  2)

- V. Is this location currently accepting new patients?  Yes  No

- VI. Office Hours:

<b>Monday</b>	Open:	Close:	<b>Tuesday</b>	Open:	Close:
<b>Wednesday</b>	Open:	Close:	<b>Thursday</b>	Open:	Close:
<b>Friday</b>	Open:	Close:	<b>Saturday</b>	Open:	Close:
<b>Sunday</b>	Open:	Close:	<input type="checkbox"/> By Appt Only		<input type="checkbox"/> 24/7

## SECTION C CHANGE IN BILLING ADDRESS OR BILLING INFO

This Billing address change affects:

- Just the individual practitioner in SECTION A  
 All practitioners associated with this Group  
*\*Please fill out ATTACHMENT H of this form*

<input type="checkbox"/>	Please update my 1099 Address <i>(a new W-9 is required. Please include a new W-9 with your submission)</i>		
<b>Provider Name as it appears on W9</b>		<b>TIN</b>	<b>Medicaid Number</b>
<b>New Billing Address</b>			
<b>Phone</b>		<b>Fax</b>	
<b>Contact Person</b>		<b>Contact Email</b>	

## SECTION D CHANGE IN MAILING ADDRESS

This Mailing address change affects:

- Just the individual practitioner in SECTION A  
 All practitioners associated with this Group  
*\*Please fill out ATTACHMENT H of this form*

<b>Provider Name or Group/Clinic Name (if applicable)</b>	
<b>New Mailing Address</b>	
<b>Phone</b>	<b>Fax</b>
<b>Contact Person</b>	<b>Contact Email</b>

## SECTION E CHANGE IN TAXONOMY

Individual in SECTION A     Group

<b>Current Taxonomy</b>	<b>Current Taxonomy Description</b>
<b>New Taxonomy</b>	<b>New Taxonomy Description</b>

## SECTION F CHANGE OF PROVIDER STATUS

Please select from drop down menu:

## SECTION G CHANGE IN MEDICAID NUMBER

Individual in SECTION A     Group

<b>Current/Old Medicaid #:</b>	<b>New Medicaid #:</b>
<b>Effective Date of Change:</b>	<b>Reason for Change:</b>



Feel free to use the space below if you would like to further describe the changes that you are needing to make:

Signature

Date

Name

Title

Submit your PCF by uploading to [www.cenpatico.com/providers/ga/provider-tools/provider-demographic-updates](http://www.cenpatico.com/providers/ga/provider-tools/provider-demographic-updates)