# 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 you CAQH application as well; your CAQH must be updated separately.
- ✓ Return PCF to www.cenpatico.com/providers/ma/provider-tools/provider-demographic-updates

| What change do you need to make? | Steps to Complete: |
|---|---|
| ☐ Change/add/delete primary address, email, telephone, and/or fax number | ✓ Complete SECTION A<br>✓ Complete SECTION B |
| ☐ Change/add/delete secondary address, telephone, and/or fax number | ✓ Complete SECTION A<br>✓ Complete SECTION B |
| ☐ Change of billing address, telephone, and or fax number | ✓ Complete SECTION A<br>✓ Complete SECTION C |
| ☐ Change of mailing address, telephone, and or fax number | ✓ Complete SECTION A<br>✓ Complete SECTION D |
| ☐ Change Taxonomy | ✓ Complete SECTION A<br>✓ Complete SECTION E |
| ☐ Change of provider status (e.g. moved out of area, capacity changes, etc.) | ✓ Complete SECTION A<br>✓ Complete SECTION F |
| ☐ Change Medicaid Number | ✓ Complete SECTION A<br>✓ Complete SECTION G |
| ☐ Discontinue Cenpatico Services | ✓ Contact your Provider Relations Rep<br>*Visit www.cenpatico.com/providers to locate your Rep's contact information* |
| ☐ Adding/changing TIN | ✓ Contact your Provider Relations Rep<br>*Visit www.cenpatico.com/providers to locate your Rep's contact information* |

## 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:

| | | | | | |
|---|---|---|---|---|---|
| **Monday** | *Open:* | *Close:* | **Tuesday** | *Open:* | *Close:* |
| **Wednesday** | *Open:* | *Close:* | **Thursday** | *Open:* | *Close:* |
| **Friday** | *Open:* | *Close:* | **Saturday** | *Open:* | *Close:* |
| **Sunday** | *Open:* | *Close:* | ☐ By Appt Only | | ☐ 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*

| ☐ Please update my 1099 Address ***(a new W-9 is required. Please include a new W-9 with your submission)*** | | |
|---|---|---|
| **Provider Name as it appears on W9** | **TIN** | **Medicaid Number** |
| **New Billing Address** | | |
| **Phone** | **Fax** | |
| **Contact Person** | **Contact Email** | |

## 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*

| **Provider Name or Group/Clinic Name (if applicable)** | |
|---|---|
| **New Mailing Address** | |
| **Phone** | **Fax** |
| **Contact Person** | **Contact Email** |

## SECTION E CHANGE IN TAXONOMY ☐ Individual in SECTION A ☐ Group

| **Current Taxonomy** | **Current Taxonomy Description** |
|---|---|
| **New Taxonomy** | **New Taxonomy Description** |

## SECTION F CHANGE OF PROVIDER STATUS

Please select from drop down menu:

## SECTION G CHANGE IN MEDICAID NUMBER ☐ Individual in SECTION A ☐ Group

| **Current/Old Medicaid #:** | **New Medicaid #:** |
|---|---|
| **Effective Date of Change:** | **Reason for Change:** |

# ROSTER OF AFFECTED PRACTITIONERS

ATTACHMENT H

All changes on this form, where indicated to affect all practitioners associated with group, will be applied to all **Cenpatico** credentialed practitioners listed below:

| First Name | Last Name | NPI | Section/s of PCF changes that are applicable |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| 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/ma/provider-tools/provider-demographic-updates