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.sunflowerhealthplan.com/providers/resources/provider-practitioner-changes/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 ✓ Complete SECTION B
☐ Change/add/delete secondary address, telephone, and/or fax number	✓ Complete SECTION A ✓ Complete SECTION B
☐ Change of billing address, telephone, and or fax number	✓ Complete SECTION A ✓ Complete SECTION C
☐ Change of mailing address, telephone, and or fax number	✓ Complete SECTION A ✓ Complete SECTION D
☐ Change Taxonomy	✓ Complete SECTION A ✓ Complete SECTION E
☐ Change of provider status (e.g. moved out of area, capacity changes, etc.)	✓ Complete SECTION A ✓ Complete SECTION F
☐ Change Medicaid Number	✓ Complete SECTION A ✓ Complete SECTION G
☐ Discontinue Behavioral Health Services	✓ Contact your Provider Relations Rep *providerrelations@sunflowerhealthplan.com*
☐ Adding/changing TIN	✓ Contact your Provider Relations Rep *providerrelations@sunflowerhealthplan.com*

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 **Sunflower Health Plan** 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.sunflowerhealthplan.com/providers/resources/provider-practitioner-changes/provider-demographic-updates