Prime Healthcare

Prime Healthcare Network

Provider Change Request Form

Please complete the form below and return along with supporting documents.

Type of Change:
- ☐ **Add/Remove Provider -** *submit with updated roster and W-9*
- ☐ **Add/Remove Service Location**
- ☐ **Provider/Group Demographic Update -** *submit W-9*

**Please <u>only</u> complete the section(s) you are requesting a change.*

☐**Add** ☐**Remove** **Effective Date** _____

Provider Information: *When adding a new provider to a group contract, please provide a copy of medical license, DEA, and NPI verification.*

Name _____ Degree_____
Specialty_____ Type I NPI _____
Office Address_____
City_____ State_____ Zip_____
Prime Facility Affiliation _____

☐**Add** ☐**Remove** **Effective Date** _____

Service Location: *If adding/removing multiple locations, please provide an updated roster.*
Street Address_____
City_____ State_____ Zip_____
Office Contact_____ Title_____
Email_____ Phone_____
Accepting New Patients _____ Offering New Services _____
☐**Add** ☐**Remove** **Effective Date** _____

Group Information:
Group Name *as listed on W9* _____
Tax ID _____ Type II NPI _____
Billing Address *as listed on W9* _____
City _____ State _____ Zip _____
Group Owner _____
Accepting New Patients _____ Offering New Services _____
Primary Point of Contact
Name_____Title_____
Phone_____ Email_____

Please return this form via fax or email, along with a W-9 to:
Prime Healthcare Management
Attn: Contracts
Fax: 909-235-4405
Email: EHPprovidercontracts@primehealthcare.com