US FAMILY HEALTH PLAN

PROVIDER CHANGE FORM

Provider Name: _____ **Individual Provider NPI:**_____

Specialty: _____ **Taxonomy:** _____

Ethnicity_____ **Additional Language(s) Spoken**_____

Current Group/Practice Name: _____

Provider Primary Practice Location_____

Telehealth availability Yes___ / No___ **Handicapped Accessible: Yes___/No____**

☐ **Change Group/Practice Name to:** _____
Group NPI:_____

☐ **Change Provider(s) Name to:** _____
[Please provide supporting documentation; i.e., current license and/or other proof of name change]

☐ **Change Practice Location Address/Phone/Fax:**
From (current): _____
To (provide new information): _____
Telehealth availability Yes___ / No___ **Handicapped Accessible: Yes___/No____**

☐ **Delete this Practice Address/Phone/Fax:** _____

☐ **Add this Practice Address/Phone/Fax to this Provider:** _____
Telehealth availability Yes___ / No___ **Handicapped Accessible: Yes___/No____**

☐ **Board Certification completion:** _____

☐ **Specialty Change/Correction:** _____ **Taxonomy Code:**_____

☐ **Other [detail]:**_____

PCP's only - Panel Status: ☐ **Open** ☐ **Closed** ☐ **Existing Patients Only**

TERMINATION:

☐ **Name of Provider leaving the Practice:** _____
Reason Provider is leaving the practice: _____
Forwarding address: _____ **Forwarding phone:** _____
If PCP; Name of provider assuming patient panel:_____

BILLING INFORMATION:
Any changes related to billing information (Name, Address, Tax ID, Group NPI) must be accompanied by a completed W9 form

☐ **Change Billing Address/Phone/Fax:**
From (current): _____
To (provide new information): _____

☐ **Add this Billing Address/Phone/Fax to this Provider**_____
_____

☐ **Change Tax ID Number: From (current):** _____ **To (provide new Tax ID#):** _____

☐ **Group NPI Number:**_____

☐ **Add Tax ID Number:** _____

(please note; new or additional Tax ID numbers may require contracting updates)

Effective Date of Change(s): _____

_____	_____
Print name of person completing this form	**Signature of person completing this form**

_____	_____	_____
Title of person completing this form	**Phone**	**Date**

Please send completed form to Credentials and Provider Maintenance department by email, fax, or mail.

Email: provnetwork@svcmcny.org Fax: 212-356-4868

Mail: USFHP – Provider Network
530 7th Avenue, 10th Floor, New York, New York 10018