

Standardized Provider Information Change Form

To ensure that our members have the most up-to-date information for Clever Care Health Plan participating providers, the Standardized Provider Information Change Form is designed for providers to submit demographic changes regarding their practice to Clever Care Community Relations and Network Development Team.

This form should be completed when adding a new provider or changing your practice name, office address, phone numbers, fax numbers, office hours, Tax Identification Number (TIN), e-mail and billing information.

Instructions for Completing the Standardized Provider Information Change Form

Section 1: PROVIDER CONTACT INFORMATION: This section identifies the provider requesting the change.

- Provider Last Name/First Name/MI: Practitioner requesting the change
- NPI - Current individual National Practitioner Identifier (NPI)
- Tax ID - Current Tax Identification Number (TIN) (Copy of W-9 is required)
- Provider Type - Current role of the provider (PCP, Specialist, Both, etc.)
- If Multiple Providers are being added. Please use the Standard Group Roster Format.

Section 2: TYPE OF CHANGE: This section identifies the type of change being requested. More than one box should be checked if needed.

Section 3: DEMOGRAPHIC CHANGE (ADDS): This section identifies the new information or demographic changes. Below are the types of demographic changes for this section.

- Add/Change TIN (W-9 form needed)
- Add Service Address - Adding new service address One per line. Fill out more forms if needed.
- Add Billing Address - Add billing address where checks and remittance are mailed
- Change Group Name - Updating the Group Practice Name (W-9 form needed)
- Add Hospital Affiliation
- Add Languages
- Add Specialty (If Board Certified, please include certification dates)

Section 4: DEMOGRAPHIC CHANGE (DELETES): This section identifies existing demographic information that needs to be terminated.

- Inactivate/Terminate TIN - Terminating an existing TIN
- Terminating Service Address - Terminating existing service address
- Terminate billing address - Terminate existing billing address where check and remittance are mailed
- Terminate Group Name – Terminate the existing Group Practice Name or affiliation

Examples:

- If changing an office and/or billing address, please complete Section 3 with new office and/or billing information and Section 4 with the office and/or billing address that needs to be terminated.
- If terminating an existing service address only, please complete Section 4.
- If changing group name, please complete Section 3 with the new group information and Section 4 with the group information that needs to be terminated.



Please send completed form with additional documentation to:
ProviderUpdates@clevercarehealthplan.com Fax No: 657-276-4714

| SECTION 1: Provider Contact Information *Section required. | | |
|---|---------------------|-----|
| Provider Last Name: | First Name: | MI: |
| NPI: | TIN: | |
| Provider Type: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Both <input type="checkbox"/> Hospitalist <input type="checkbox"/> Ancillary/Allied Health | | |
| Contact Person Submitting Request: | | |
| Phone: | Date of Submission: | |

Please complete all applicable information below.

| SECTION 2: Please indicate the type of change (Check all that apply and include effective for each item checked) *Section Required | | | |
|---|----------------|--|----------------|
| <input type="checkbox"/> Practice Information | Effective date | <input type="checkbox"/> Specialty | Effective date |
| <input type="checkbox"/> Billing Information (+) | | <input type="checkbox"/> Languages | |
| <input type="checkbox"/> Provider/Group Name | | <input type="checkbox"/> Hospital Affiliation | |
| <input type="checkbox"/> Panel Status | | <input type="checkbox"/> Medical Group/IPA Affiliation | |
| + Please submit a signed, dated W-9 form for all Tax Identification Number changes | | | |

If applicable, please attach a separate list of additional locations where address update is needed.

| SECTION 3: Demographic Change | | | | | | | |
|---|----|---|----|---|-----|-----------|-----|
| Enter new information or additional address below: | | | | | | | |
| Address Type: <input type="checkbox"/> Office <input type="checkbox"/> Billing | | | | Panel Status: <input type="checkbox"/> Open Panel <input type="checkbox"/> Closed Panel | | | |
| Group/Practice Name: | | | | Group NPI: | | | |
| Address Line 1: | | | | | | | |
| Address Line 2: | | | | | | | |
| City: | | | | State: | | Zip Code: | |
| Phone: | | | | Fax: | | | |
| Office Hours: | M: | T: | W: | TH: | FR: | SA: | SU: |
| Specialty: | | Board Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Certification Date: | | | |
| | | | | Certification Expiration Date: | | | |
| Languages: | | | | | | | |
| Hospital Affiliation(s): | | | | | | | |
| Wheelchair Accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Email: | | | | | |
| TIN: | | TIN Name: | | | | | |

If applicable, please attach a separate list for additional locations that need to be terminated.

| SECTION 4: Demographic Change | | |
|--|------------|-----------|
| Enter old information that needs to be terminated: | | |
| Address Type: <input type="checkbox"/> Office <input type="checkbox"/> Billing | TIN | |
| Group/Practice Name: | Group NPI: | |
| Address Line 1: | | |
| Address Line 2: | | |
| City: | State: | Zip Code: |

Please allow 30 days to process your request. Tax ID updates cannot be processed without a completed W-9. If you have any questions, please contact Community Relations & Network Development at 562-888-8802 x3050 or ProviderUpdates@CleverCareHealthPlan.com.