New Single Form to Communicate Name, Address, and Other Office Changes to Payers Now Available

To make sure that health plans and their members have the most up-to-date information about your practice, the Mass Collaborative* is pleased to introduce the ***Standardized Provider Information Change Form.*** When you are changing your practice name, address, phone numbers, e-mail, billing company, or other practice information, you only need to complete this single form and send it via e-mail, fax, or US mail to each health plan you contract with instead of completing a different form for each health plan. Please note this form is not to be used for facilities/institutions. The following health plans now accept this form:

- Blue Cross Blue Shield of Massachusetts
- Boston Medical Center Healthnet Plan
- Celticare Health Plan of Massachusetts
- Fallon Community Health Plan
- Fallon Total Care
- Harvard Pilgrim Health Care
- Health New England
- Neighborhood Health Plan
- Network Health
- Tufts Health Plan
- Senior Whole Health
- UniCare State Indemnity Plan

This form should not be used to submit credentialing or contractual changes. It is also not for providers who are new to the plan. Continue to use individual health plan forms for those changes. In some circumstances, individual health plans may need to follow up with providers for additional information regarding a demographic change.

Questions?
For questions about specific health plan policies or requirements, contact that health plan directly.

** The Mass Health Collaborative is a multi-stakeholder group committed to reducing health care administrative burdens and costs. Members of the Mass Collaborative include the Massachusetts Hospital Association, Massachusetts Medical Society, Blue Cross Blue Shield of Massachusetts, the Massachusetts Association of Health Plans, the Massachusetts Health Data Consortium, MassHealth, Healthcare Administrative Solutions, as well as many local payers and providers.*

STANDARDIZED PROVIDER INFORMATION CHANGE FORM

COMPLETE ALL APPLICABLE INFORMATION. INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.
NOT FOR NEW PROVIDERS OR CONTRACTUAL OR CREDENTIALING CHANGES.

1. INDICATE CHANGE(S) BEING SUBMITTED:** ***(Check all that apply — please include effective date for each item checked.)
****Section required.***

	Effective date		***Effective date***
☐ Practice information *(Complete sections 2, 3, 6)*	_____	☐ Panel status *(Complete sections 2, 4, 6)*	_____
☐ Billing information *(Complete sections 2, 3, 6)*	_____	☐ Termination *(Complete sections 2, 5, 6)*	_____
☐ Provider name *(Complete sections 2, 6)*	_____		

Indicate documents included: ☐ W9 ☐ Provider Roster ☐ Other _____

PLEASE COMPLETE THE APPLICABLE SECTIONS BELOW TO UPDATE YOUR INFORMATION.

2. PROVIDER INFORMATION:** ****Section required.

Provider Last Name:	First Name:	MI:
Provider Former Name *(if applicable)*:		
NPI#:	PTAN# *(if applicable)*:	TAX ID#:
Provider Type: ☐ PCP ☐ Specialist ☐ Both ☐ Hospitalist only ☐ Ancillary/Allied/Mid-Level		
Practice/Business name:		
Street:		
City:	State:	Zip:
Phone:	Fax:	
Provider Email Address:		

IF APPLICABLE, PLEASE ATTACH A SEPARATE LIST WITH THE NAMES AND NPI NUMBERS OF ALL OF THE PROVIDERS IN THIS GROUP FOR WHOM THE ADDRESS CHANGE IS APPLICABLE.

3. ADDRESS INFORMATION:

ENTER NEW OR ADDITIONAL ADDRESSES BELOW		**ENTER OLD ADDRESSES *TO BE TERMINATED* BELOW**	
Address type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing		Address type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing	
Address line 1:		Address line 1:	
Address line 2:		Address line 2:	
City:		City:	
State:	Zip:	State:	Zip:
Phone:	Fax:	Phone:	Fax:

Address type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing		Address type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing	
Address line 1:		Address line 1:	
Address line 2:		Address line 2:	
City:		City:	
State:	Zip:	State:	Zip:
Phone:	Fax:	Phone:	Fax:

Contact person completing form: _____ Phone: _____

(continued on next page)

STANDARDIZED PROVIDER INFORMATION CHANGE FORM (*CONTINUED*)

Provider Name: _____

4. PRIMARY CARE PANEL STATUS: ***May be impacted by contract terms and follow-up may be required.***

- ☐ Open panel
- ☐ Close panel
- ☐ Accepting existing patients only
- ☐ Concierge practice
- ☐ Nursing home only
- ☐ Other *(please specify)* _____

5. TERMINATION: ***Effective date may be impacted by contract terms and follow-up may be required.***

Reason for termination, please check only one box:

- ☐ Resigned
- ☐ Retired
- ☐ Deceased
- ☐ Leave of absence*
- ☐ Moved out-of-state
- ☐ Practice closed
- ☐ Provider sanctioned*
- ☐ Sabbatical*
- ☐ Provider transferred to *(group name)* _____
- ☐ Other _____

**Please provide a separate explanation of the details to the plan (i.e., duration of absence for leave/sabbatical or sanction specifics).*

6. CONTACT PERSON SUBMITTING INFORMATION:** ****Section required.

Name:	Title:
Phone:	Fax:
Email:	
Date of submission:	

SUBMISSION INFORMATION:

Blue Cross Blue Shield of MA Provider Enrollment Dept. PO Box 55350 Boston, MA 02205-5350 Email: provider-enrollment@bcbsma.com Fax: (617) 246-7771 Phone: (800) 316-BLUE (2583)	Boston Medical Center HealthNet Plan Provider Processing Center 2 Copley Place, Suite 600 Boston, MA 02116 Email: BMCHP.providerprocessingcenter@bmchp.org Fax: (617) 897-0818 Provider Processing Center: (888) 566-0008	CeltiCare Health Plan of Massachusetts Attn: Provider Services 200 West Street, Suite 250 Waltham, MA 02451 Email: providerupdatesma@centene.com Fax: (855) 227-6805 Phone: (866) 895-1786
Fallon Community Health Plan One Chestnut Place 10 Chestnut Street Worcester, MA 01608 Email: askfchp@fchp.org Fax: (508) 368-9902 Provider Services: (866) 275-3247, Opt. 4	Harvard Pilgrim Health Care Attn: Provider Processing Center 1600 Crown Colony Drive, 2nd Floor Quincy, MA 02169 Email: PPC@harvardpilgrim.org Fax: (866) 884-3843 Provider Service Center: (800) 708-4414	Health New England Attn: Provider Enrollment Dept. One Monarch Place, Suite 1500 Springfield, MA 01144 Email: penrollment@hne.com Fax: (413) 233-2665 Phone: (800) 842-4464, ext. 5344
Neighborhood Health Plan Credentialing Department 253 Summer Street Boston, MA 02210-1120 Email: pec@nhp.org Fax: (617) 526-1982 Provider Services: (855) 444-4647	Network Health 101 Station Landing, 3rd Floor Medford, MA 02155 Fax: (781) 393-3121 Provider Contracting Service: (888) 257-1985	Tufts Health Plan Provider Information Department 705 Mount Auburn Street Watertown, MA 02472 Fax: (617) 972-9044 Phone: (617) 972-9495
Senior Whole Health Attn: Provider Relations 58 Charles Street Cambridge, MA 02141 Email: providerrelations@seniorwholehealth.com Fax: (617) 551-4185 Phone: (617) 494-5353	UniCare State Indemnity Plan Provider Relations Department PO Box 9022 Andover, MA 01810 Email: unicareproviderrelations@anthem.com Fax: (978) 474-6188 Phone: (800) 480-7587	

IF APPLICABLE, SUBMIT COPY OF COMPLETED FORM TO IPA/PHO COORDINATOR OR ADMINISTRATOR.