The HealthPlan

Request for Addition(s)/Deletion(s) to Existing Individual/Group

Please note that this form may be used for providers of The Health Plan to submit changes in Tax ID#, Address, Telephone #, Remit/Pay to Address, Adding or Deleting Practitioners.

Name of Group (DBA name) _____ Tax ID# _____

Individual/Group Specialty _____Individual NPI Number: _____

Main Practice Address – Primary physical practice location (PO Box numbers are **NOT** acceptable)

_____ Telephone Number: (____) _____

_____ Fax Number: (____) _____

_____ Member Access Number (____) _____
Members can call an appointment for this location

Practitioner Name	Date of Birth	CAQH ID	NPI Individual NPI	Practitioner Specialty	Add	Delete *	Effective Date of Change
_____	_____	_____	_____	_____	☐	☐	_____
_____	_____	_____	_____	_____	☐	☐	_____
_____	_____	_____	_____	_____	☐	☐	_____
_____	_____	_____	_____	_____	☐	☐	_____

* Deletions – Please provide the following information for providers being deleted from the Group.

Practitioner Name	NPI Number	New Address (if known)	New Telephone Number
_____	_____	_____	_____
_____	_____	_____	_____

Billing Guidelines and Certification

1. We hereby agree to only bill those services performed by individual providers in the group.
2. We agree that every 1500 claim form submitted will include the NPI number of the individual provider who actually performed the service (place in Block 24J of the claim or in any other location as determined in the future).
3. We agree to notify the plan in writing of any changes to the group prior to the effective date of each change. (i.e., additions and terms, address changes, etc)
4. We understand that for certain networks all individual providers must be fully credentialed in order for the provider to be able to bill directly before rendering services to members.
5. We have carefully reviewed the forms and applications associated with the establishment of this agreement and each individual provider in our account has verified the accuracy and completeness of all information provided.

On behalf of the group, I certify that all individual providers in the group have reviewed and agree to be bound by the above guidelines. I represent and warrant I have the authority to bind the individual and sign on their behalf.

_____ _____
Signature of Authorized Representative of Group Date

_____ (_____)_____
Title Telephone Number

Please fax the completed form to Provider Relations 740-695-7883