Community Health Partners℠
PHYSICIAN HOSPITAL ORGANIZATION

Provider Add or Change Form

Please complete this form for new providers and to submit any changes in office location, telephone, fax, Tax ID number, etc.

- **To avoid a delay in processing, please complete this form with all information requested.**
- **All changes require 90-120 days for implementation. Please refer to Effective Date Policy.**
- **Please attach populated W9 and example copy of CMS1500 or UB claim form**
- **Return to fax 239.659.7791. >> Please explain change: check all that apply:**

New Provider ☐ New TID ☐ New Billing ☐ New Primary ☐ New Additional Address☐ New phone/fax ☐
Change/add specialty ☐ Add Additional TIN ☐ Other:

- **If a group practice, please attach a roster of all providers affiliated.**

Today's Date: Click to enter a date.	**Provider Name:**
Old Office Address	***New Primary Office Address***
Group Name:	Group Name:
Address:	Address:
City:	City:
State/Zip:	State/Zip:
Telephone: Fax:	Telephone: Fax:
Email address:	Email address:
Tax ID number:	Tax ID number:
Should old TIN be Terminated ☐ Yes ☐ No	Effective date of change: Click here to enter a date.

Additional Office Address (attach list if needed)	***Mailing Office Address (if different from Primary)***
Group Name:	Group Name:
Address:	Address:
City:	City:
State/Zip:	State/Zip:
Telephone: Fax:	Telephone: Fax:
Email address:	Email address:
Tax ID number:	Tax ID number:
Effective date of change: Click to enter a date.	Effective date of change: Click to enter a date.

Billing Office Address	Primary Specialty:
Group Name:	Secondary Specialty:
Address:	Is Dr. staffing Walk-in-Center:
City:	Languages: Age limits:
State/Zip:	Office Hours:
Telephone: Fax:	Medicare #:
Email:	Medicaid #:
Billing Manager:	NPI # : Individual
Billing Manager Phone:	NPI #: Group:
Tax ID Number:	Physicians Reg Med Ctr Status:
Effective date of change: Click to enter a date.	NCH Status:
Do you bill on HCFA or UB92? **(please provide copy with boxes 31, 32, 33 populated**	Web address: (☐Yes, link to CHP website)
Please list physicians who will cover in your absence:	

Person Completing Form:
Name: Title:
Email Address: