

Standardized Group Practice/Individual Provider Update Form

This form is to be utilized for both practice and individual provider updates, additions and deletions. Practice changes REQUIRE a W-9. There are no required forms for individual provider changes. Please fill out all required fields to ensure timely processing. Please allow up to 10 business days for your provider portal to reflect any changes (apart from individual provider additions). If terminating a provider or practice, complete only Sections 1 & 2 and SIGN.

Today's Date:

Section 1: General

Practice Name:	
Practice NPI:	Practice Tax ID:
Individual Provider Name:	
Provider NPI:	
Administrator Name:	Title:
Phone:	Email:

Section 2: Reason for Form Submission

Select all options that apply

- | | | |
|---|--|---|
| <input type="checkbox"/> Add NEW Individual Provider | <input type="checkbox"/> Terminate Practice Location(s) Effective: | <input type="checkbox"/> Practice Tax ID Change |
| <input type="checkbox"/> Terminate Individual Provider Effective: | <input type="checkbox"/> Report Phone/Email/Fax Changes | <input type="checkbox"/> Individual Provider Name Change |
| <input type="checkbox"/> Add Additional Practice Location(s) | <input type="checkbox"/> Practice Name | <input type="checkbox"/> Other (please describe in section 6) |

Section 3: Individual Provider Updates

Only complete this section for individual provider additions and name updates. NEW PROVIDERS REQUIRE ALL FIELDS. Current provider updates require NPI and all applicable fields. New providers will be required to move through the credentialing process, no changes will be reflected on the provider portal until approval is received. To ensure timely approval, please ensure all information is updated through CAQH and allow our credentialing entity, PPMC, access to view your file. Check this box certifying you understand this information. →

<i>NEW NAME (if applicable):</i>	
Credentials:	CAQH #:
If "Other Credential", please specify:	
CAQH Attested w/ in past 60 Days: <input type="checkbox"/> Y <input type="checkbox"/> N	Attestation Date:
Languages Spoken:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
General Certificate/Primary Specialty:	
Fellowship/Subspecialty:	

Practice Locations:	Hospital Affiliations:
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Section 4: Practice Updates

A W-9 is REQUIRED for all practice changes and must be submitted with this form to be considered complete for processing.

<input type="checkbox"/> New	<input type="checkbox"/> Term	<input type="checkbox"/> Update	Effective Date:
Street Address/PO Box:		Suite #:	
City:	State:	Zip:	
County:		NPI if applicable:	
Address Type: <input type="checkbox"/> Practice <input type="checkbox"/> W-9 <input type="checkbox"/> 1099 <input type="checkbox"/> Remit <input type="checkbox"/> Correspondence <input type="checkbox"/> Administrative			
<input type="checkbox"/> New	<input type="checkbox"/> Term	<input type="checkbox"/> Update	Effective Date:
Street Address/PO Box:		Suite #:	
City:	State:	Zip:	
County:		NPI if applicable:	
Address Type: <input type="checkbox"/> Practice <input type="checkbox"/> W-9 <input type="checkbox"/> 1099 <input type="checkbox"/> Remit <input type="checkbox"/> Correspondence <input type="checkbox"/> Administrative			
<input type="checkbox"/> New	<input type="checkbox"/> Term	<input type="checkbox"/> Update	Effective Date:
Street Address/PO Box:		Suite #:	
City:	State:	Zip:	
County:		NPI if applicable:	
Address Type: <input type="checkbox"/> Practice <input type="checkbox"/> W-9 <input type="checkbox"/> 1099 <input type="checkbox"/> Remit <input type="checkbox"/> Correspondence <input type="checkbox"/> Administrative			
<input type="checkbox"/> New	<input type="checkbox"/> Term	<input type="checkbox"/> Update	Effective Date:
Street Address/PO Box:		Suite #:	
City:	State:	Zip:	
County:		NPI if applicable:	
Address Type: <input type="checkbox"/> Practice <input type="checkbox"/> W-9 <input type="checkbox"/> 1099 <input type="checkbox"/> Remit <input type="checkbox"/> Correspondence <input type="checkbox"/> Administrative			
<input type="checkbox"/> New	<input type="checkbox"/> Term	<input type="checkbox"/> Update	Effective Date:
Street Address/PO Box:		Suite #:	
City:	State:	Zip:	
County:		NPI if applicable:	
Address Type: <input type="checkbox"/> Practice <input type="checkbox"/> W-9 <input type="checkbox"/> 1099 <input type="checkbox"/> Remit <input type="checkbox"/> Correspondence <input type="checkbox"/> Administrative			

Section 5: Practice Contact Updates

New Phone:	New Email:
New Fax:	New Website:

Section 6: Comments

Print Name: _____

Sign Name: _____

Date: _____

Please PRINT, SIGN and SCAN form with supporting documents to

EMAIL 

FAX: 614-423-2873

or **MAIL** to:

Trusted Senior Care
Advantage 440 Polaris
Parkway, Ste. 550
Westerville, OH 43082

For new providers, the credentialing process can take up to 45 days from receipt of request to reflect on our provider portal.

For all other changes, please allow up to 30 days from receipt of request to reflect on our provider portal.