Priority Health

Provider Change Form

Complete the applicable sections below to make changes to an existing provider or organization. Save your completed document for your records. To submit it to us:

1. Log into your **prism** account.
2. Click on **Enrollments & Changes**.
3. Click on **Change Individual Provider or Organization**.
4. Follow the directions as indicated.

About the provider			
Name/degree		**Provider NPI**	
DOB		**Provider specialty**	
Gender		**Provider primary hospital**[1]	
Group/facility name		**Group/facility NPI**	
Provider ID/vendor #		**Primary billing taxonomy code**	
Description of request			

Physician organization (PO)/physician hospital organization (PHO)/Clinically Integrated Network (CIN)	
Is this provider a member of a PO, PHO or CIN?	Yes No
If yes, what's the PO, PHO or CIN you're contracted under for this request?	
Will this be your *primary* PO, PHO or CIN if you participate with more than one?	Yes No N/A

Contact/person responsible for completing this form			
Name		**Today's date**	
Mailing address			
Phone number			
Email address			

Provider's practice setting			
Is the provider changing from a PCP to a specialist?		Yes	No
Is the provider a hospitalist?		Yes	No
Is the provider practicing exclusively within the hospital setting?		Yes	No
Does the provider offer acupuncture services?		Yes	No
Does the provider offer Virtual visits?	Yes, both virtual and physical	Yes, virtual only	No, physical only

Change a group or facility's name, tax ID or NPI			
Current name		**New name**	
Current tax ID		**New tax ID**	
Current NPI		**New NPI**	
Current DBA name		**New DBA name**	

[1]*Required field for all primary care providers and specialty care providers except DCs, ODs and BH APPs*

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Change provider's name			
Current name		New name	

Change PCP age panel limits			
	Family practice (0-99+ years)		General practice (0-99+ years)
	IM/peds (0-99+ years)		Internal medicine (16-99+ years)
	Pediatrics (0-21 years)		Gynecology (13-99+ years)
	OB/Gyn (13-99+ years)		

Product participation status					
	Open to new members	Closed to new members	Reason for closing to new members		
			Panel full	Part-time	Other
HMO					
PPO					
Medicare					
Medicaid*					

Product open/closed status (PCP only)					
	Open to new members	Closed to new members	Reason for closing to new members		
			Panel full	Part-time	Other
HMO					
PPO					
Medicare					
Medicaid[2]					
Do you participate with Children's Special Health Care Services (CSHCS)?			Yes[3]	No	

Demographic information (attach additional addresses to this form)			
Add location[4] (must complete demographic information section in full)		Effective date	
Group billing name (name on claim)			
Group "name on the Door" of this location			
Practice website			
Address		City	
State	Zip	County	
Phone		Fax[5]	
Can Priority Health members call this phone number to make an appointment with the provider at this location?	Yes No	Does this practitioner work 20 or more hours at this location?	Yes No
Address type	Primary	Secondary	
	Billing/remit	Tax (include updated W-9)	
	Other:		
Billing TIN			
Group billing NPI			
Provider's scope at this location	PCP, physician	Specialist, physician	
	Hospitalist/rounding	Assisting in surgeries	
	APP/midlevel PCP	APP/midlevel specialist	
	Behavioral health practitior	Other:	

[2]To be eligible for Medicaid participation, you must be actively enrolled in CHAMPS.
[3]If you participate with Children's Special Health Care Services (CSHCS), you must complete the CSHCS Individual or Group Provider Attestation form (pages 6-7)
[4]If this is a new FQHC, RHC or THC location, please submit a prism application for a new organization
[5]You must notify edisetup@priorityhealth.com for any fax number change where electronic claim receipt notices are sent

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APP only		
NPI of the supervising Priority Health participating physician with whom the APP holds a current practice agreement (also known as a collaboration agreement)		
How does the APP provider bill?	Bills independently	Bills under a supervising physician

Office hours							
	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Building/facility open hours							

Cross coverage (list covering providers)			
Name, title		**Specialty**	
Address		**Phone**	
Name, title		**Specialty**	
Address		**Phone**	
Name, title		**Specialty**	
Address		**Phone**	
If none, please explain			
Do you currently admit and care for hospitalized patients?		Yes	No
If no, explain the formal inpatient coverage arrangement you have for each inpatient facility			

Type of term – Provider leaving a participating Priority Health Network group. Priority health requires a written notice 90 days in advance. Find requirements and responsibilities in our Provider Manual at priorityhealth.com/provider for more information. (Attach additional address to this form.)

Priority Health maintains that the primary care relationship resides between the member and the PCP. Members will remain with their current PCP if the change of location distance is less than 30 miles. When applicable, Priority Health will reach out to the provider group to determine where members should be transferred. Members will be transferred to a new PCP when any of the following reasons exist:

- Provider deceased or retired
- Provider changes from a PCP to SPC
- PCP moved out of current Priority Health Michigan service are or more than 30 miles from their current primary location
- PCP is no longer participating/contracted
- Age panel limit with member transfer Network termination due to sanction/license suspension

Which of these options apply to this termination?		Removing a location	Leaving a location	Leaving a group		Leaving a PHO	
Do you want to terminate your affiliation with the Priority Health Network?		Yes	No	**Termination effective date**			
Group billing name (name on claim)							
Group "name on the door" of this location							
Group TIN			**Type 2 NPI**				
Address							
City			**State**			**Zip**	
Reason for leaving			Deceased		Leave of absence		
			Retired		Moving to another group		
			Moving outside the service area		Moving to another location under the same group		
PCP authorizing EOC?			EOC terms accepted		EOC terms refused		

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Behavioral health providers only		
Areas of focus	**Adding**	**Terming**
Applied Behavior Analysis (ABA)		
Attention Deficit Disorders (ADD/ADHD)		
Bariatric Evaluations		
Behavioral Therapy		
Chronic Medical Illness		
Diagnostic Assessments		
Diagnostic Evaluations for Autism Spectrum Disorder		
Dialectical Behavior Therapy (DBT)		
Eating Disorders		
Eye Movement Desensitization & Reprocessing (EMDR)		
Faith-Based Counseling		
Gender Identification/Transgender		
Grief & Loss		
Internal Family Systems		
Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ+)		
Medication-Assisted Treatment (MAT) for Opioid Use - Suboxone/Buprenorphine		
Neuropsychology (training and work experience required)		
Obsessive Compulsive Disorder (OCD)		
Outpatient Substance Abuse Disorder		
Play Therapy		
Postpartum Depression/Related Mental Health Disorder		
Post-Traumatic Stress Disorder (PTSD)		
Psychological Testing & Assessment		
Transcranial Magnetic Stimulation (TMS)		

Additional services – Select any that apply		
Ambulance	Dialysis	Independent diagnosis services
Anesthesiology group	Diabetes prevention program	Pathology group
Audiology Hearing aid supplier Hearing screenings	Durable medical equipment Prosthetics Bathroom safety bars	Prosthetics/orthotics
Cardiac catheterization	Emergency medicine group	Radiology/imaging centers Diagnostic radiology Mammography Therapeutic radiology
Cardiac surgery program	Health department	
Centering pregnancy	High-tech services including: CT, PET, etc.	Other:
Critical care services/ICU		

Provider Change Form acknowledgement – This form will be used as a supplement to the provider's Council for Affordable Quality Healthcare (CAQH) application

I consent to the release of this information to the Council for Affordable Quality Healthcare (CAQH), for the purpose of allowing Priority Health access to my information in the CAQH Universal Credentialing Data Source (UC).

By signing this form, I affirm that the information supplied is correct and complete, and that any misstatements in, or omissions from this form may be cause for denial of credentialing.

Provider agrees by submission of this request to abide by the terms of the Participation Agreement between Priority Health and the designated accountable care network entity listed on Page 1.

Physician/representative signature	*Your typed name confirms your electronic*

Before you submit this form:

Verify all information is complete and any required supporting documentation is included. Incomplete forms and missing documentation create delays.

Children's Special Health Care Services (CSHCS) Provider Attestation

The undersigned primary care physician hereby certifies as follows:

1. I currently serve children, youth or young adults with complex chronic health conditions.
2. My practice has implemented a procedure to identify children, youth or young adults with chronic health conditions.
3. My practice will provide expanded appointments when a child, youth or young adult patient has complex needs and requires more time.
4. My practice coordinates care for children, youth or young adults who receive services from multiple professionals including, but not limited to, pediatric subspecialists, physical therapists and mental health professionals.
5. My practice provides services appropriate for Health Care Transition, including but not limited to; the use of a transition readiness assessment and adoption of a transition policy that is publicly posted and specifies the transition time frame and transition approach.
6. My practice is open to (select one):

   New patients (children, youth or young adults) with complex chronic health conditions

   Existing patients (children, youth or young adults) with complex chronic health conditions

Date:

Signature:

Printed name:

NPI number:

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Children’s Special Health Care Services (CSHCS) Provider Group Attestation

The undersigned single signature authority hereby certifies that physicians within ____ (Group Name):

1. Currently serve children, youth or young adults with complex chronic health conditions.
2. Their practices have implemented a procedure to identify children, youth or young adults with chronic health conditions.
3. Their practices will provide expanded appointments when a child, youth or young adult patient has complex needs and requires more time.
4. Their practices coordinate care for children, youth or young adults who receive services from multiple professionals including, but not limited to, pediatric subspecialists, physical therapists and mental health professionals.
5. Their practices provide services appropriate for Health Care Transition, including but not limited to; the use of a transition readiness assessment and adoption of a transition policy that is publicly posted and specifies the transition time frame and transition approach.
6. My practice is open to (select one):

    New patients (children, youth or young adults) with complex chronic health conditions

    Existing patients (children, youth or young adults) with complex chronic health conditions

Date:

____

Signature:

____

Printed name (Single Signature Authority)**:**

____

NPI number:

____

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