PriorityHealth

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
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 practitioner			☐ Other:	

[2]If requesting a new Medicaid contract, you must attach a Medicaid Disclosure Form (page 5)
[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 area 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	

Behavioral health providers only		
Professional services	**Adding service**	**Terming service**
Domestic violence	○	○
Dual diagnostics	○	○
Gay/lesbian issues	○	○
Post-traumatic stress disorder	○	○
Sexual trauma	○	○
Transgender issues	○	○
Eating disorders	○	○
Opiate addiction treatment	○	○
ADD/ADHD (criteria: Doctorate level, full licensure)	○	○
Psychological testing (criteria: Doctorate level, full licensure)	○	○
EMDR (copy of certificate required)	○	○
Neuropsychology (training and work experience required)	○	○
Autism	○	○
Age panel	☐ Children (0-12 years)	
	☐ Adolescents (12-18 years)	
	☐ Adults (18-99 years)	
	☐ Other (specify):	

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, MRI, 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 signature*

Before you submit this form:

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

Medicaid Disclosure Requirement Form for Medicaid Network Providers

Federal Regulation # 42 CFR §455.106(a), 42 CFR §455.101 and 42 CFR §455.104

Provider Group/Organization Name: _____
Provider Name: _____
Signature of person completing this form: _____ **Date:** _____

Has any person who has ownership or control interest in the provider, or is an agent or managing employee of the provider, ever been convicted of a criminal offence related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of these programs?

- ○ No
- ○ Yes – If yes, please list below:

	First name	Middle initial	Last name
1.			
2.			
3.			

Managing employee section

Please provide the name, Social Security number and home address for any employee who meets the definition of managing employee.*

	First name/Middle initial/Last name	Social Security Number	Home Address
1.			
2.			
3.			

Ownership section

Please provide the name, Social Security number and home address for all owners with 5% or more ownership or control interest in the entity. (See 42 CFR §455.104)

	First name/Middle initial/Last name	Social Security Number	Home Address
1.			
2.			
3.			

** Managing employee is defined in 42 CFR §455.101 as a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.*

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

The undersigned primary care physician hereby certifies as follows:

1. I currently serve children or youth with complex chronic health conditions.
2. My practice has implemented a procedure to identify children or youth with chronic health conditions.
3. My practice will provide expanded appointments when a child or youth patient has complex needs and requires more time.
4. My practice coordinates care for children or youth who receive services from multiple professionals including, but not limited to, pediatric subspecialists, physical therapists and mental health professionals.
5. My practice is open to (select one):
   - New patients (children or youth) with complex chronic health conditions
   - Existing patients (children or youth) with complex chronic health conditions

Date: _____

Signature: _____
Printed name: _____
NPI number: _____

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 or youth with complex chronic health conditions.
2. Their practices have implemented a procedure to identify children or youth with chronic health conditions.
3. Their practices will provide expanded appointments when a child or youth patient has complex needs and requires more time.
4. Their practices coordinate care for children or youth who receive services from multiple professionals including, but not limited to, pediatric subspecialists, physical therapists and mental health professionals.
5. My practice is open to (select one):
   New patients (children or youth) with complex chronic health conditions
   Existing patients (children or youth) with complex chronic health conditions

Date: _____

Signature: _____
Printed name (Single Signature Authority)**:** _____
NPI number: _____