Jade | HEALTH CARE MEDICAL GROUP
翡翠東華醫師協會

Provider Information Change Form

Instructions: Complete all applicable information. Incomplete submissions maybe returned unprocessed. Not for new providers or contractual or credentialing changes. Please submit this form no later than 90 days from the effective date. To submit this form, please fax to 415-217-4178 or email to info@jadehcmg.com

Section 1. INDICATE CHANGE(S) BEING SUBMITTED: (Check all that apply):

Effective date: _____

☐ Practice Information (Complete sections 2, 3, 4, 7)

☐ Billing Information (Complete sections 2, 3, 7)

☐ Provider Name (Complete sections 2, 7)

☐ Panel Status (Complete sections 2, 5, 7)

☐ Termination (Complete sections 2, 6, 7)

Indicate documents included: ☐ W9-Form ☐ Provider Roster ☐ Other _____

Section 2. PROVIDER INFORMATION:

Provider Last Name:_____ First Name: _____ MI: _____

Provider Former Name (if applicable): _____

NPI#: PTAN# (REQUIRED): _____TAX ID# (W-9 Form Required): _____

Provider Type: ☐ PCP ☐ Specialist ☐ Both ☐ Hospitalist only ☐ Ancillary/Allied/Mid-Level

IF APPLICABLE, PLEASE ATTACH A SEPARATE LIST WITH THE NAMES AND NPI NUMBERS OF ALL OF THE PROVIDERS IN THIS GROUP FOR WHOM THE ADDRESS CHANGE IS APPLICABLE.

Section 3. UPDATE ADDRESS INFORMATION: Enter New or Additional Addresses Below (If Applicable)

Address type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing Address

Add Address:

Address line 1: _____ Address line 2: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

Revision Date: 3/2017

Remove Address:

Address line 1: _____ Address line 2: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

Section 4: PRACTICE INFORMATION: Enter New Information about your Practice

Phone: _____Fax: _____

Provider Email Address:_____

Staff Language Capabilities: _____

Handicap Access? : _____ Yes _____ No

Office Hours: Mon_____Tues_____Weds_____Thurs_____Fri_____

Sat _____ Sun _____

Section 5. PRIMARY CARE PANEL STATUS: May be impacted by contract terms and follow-up may be required.

Please check the applicable boxes:

☐ Open panel ☐ Close panel ☐ Accepting existing patients only

☐ Concierge practice ☐ Nursing home only ☐ Other (please specify) _____

Section 6. TERMINATION: Effective date may be impacted by contract terms and follow-up may be required.

Reason for termination, please check only one box:

☐ Resigned ☐ Retired ☐ Deceased ☐ Leave of absence* ☐ Moved out-of-state ☐ Practice closed
☐ Provider sanctioned* ☐ Sabbatical* ☐ Provider transferred to (group name) ☐ Other

*Please provide a separate explanation of the details to the medical group (i.e., duration of absence for leave/sabbatical or sanction specifics).

Section 7. CONTACT PERSON - SUBMITTING INFORMATION:

Name: _____Title: _____

Phone: _____Fax: _____

Email: _____Date of submission: _____

Signature: _____

Note: Please allow 7 – 10 business days for your change to be processed