

Provider Information Change Form

Print or type all of the information on this form. Mail or fax the completed form and any additional documentation to the address on the second page.

		Date : / /
Nine-Digit Texas Provider Identifier (TPI):		Provider Name:
National Provider Identifier (NPI):		Primary Taxonomy Code:
Atypical Provider Identifier (API):		Benefit Code:

List any additional TPIs that use the same provider information:

TPI:	TPI:	TPI:
TPI:	TPI:	TPI:
TPI:	TPI:	TPI:

Physical Address—The physical address cannot be a PO Box.

Street address	City	County	State	Zip Code
Telephone: ()	Fax Number: ()	Email:		

Accounting/Mailing Address—All providers who make changes to the Accounting/Mailing address must submit a copy of the W-9 Form along with this form.

Street Address	City	State	Zip Code
Telephone: ()	Fax Number: ()	Email:	

Secondary Address

Street Address	City	State	Zip Code
Telephone: ()	Fax Number: ()	Email:	

Type of Change (check the appropriate box)

<input type="checkbox"/>	Change of physical address, telephone, and/or fax number
<input type="checkbox"/>	Change of billing/mailling address, telephone, and/or fax number
<input type="checkbox"/>	Change/add secondary address, telephone, and/or fax number
<input type="checkbox"/>	Change of provider status (e.g., termination from plan, moved out of area, specialist) <i>Explain in the Comments field</i>
<input type="checkbox"/>	Other (e.g., panel closing, capacity changes, and age acceptance)

Comments:

Tax Information—Tax Identification (ID) Number and Name for the Internal Revenue Service (IRS)

Tax ID number:	Effective Date:
Exact name reported to the IRS for this Tax ID:	

Provider Demographic Information

Languages spoken other than English:			
Provider office hours by location:			
Accepting new patients by program (check one):	Accepting new patients <input type="checkbox"/>	Current patients only <input type="checkbox"/>	No <input type="checkbox"/>
Patient age range accepted by provider:	Additional services offered (check one): HIV <input type="checkbox"/> High Risk OB <input type="checkbox"/> Hearing Services for Children <input type="checkbox"/>		
Patient gender limitations: Female <input type="checkbox"/> Male <input type="checkbox"/> Both <input type="checkbox"/>			

Signature and date are required or the form will not be processed.

Provider signature:	Date: / /
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Instructions for Completing the Provider Information Change Form

Signatures

- The provider's signature is required on the Provider Information Change Form for any and all changes requested for individual provider numbers.
- A signature by the authorized representative of a group or facility is acceptable for requested changes to group or facility provider numbers.

Change of Address

- Performing providers (physicians performing services within a group) may *not* change accounting information.
- Changes to the accounting or mailing address require a copy of the W-9 form.
- For Texas Medicaid fee-for-service, a change in ZIP Code requires copy of the Medicare letter for Ambulatory Surgical Centers.

Tax Identification Number (TIN)

- TIN changes for individual practitioner provider numbers can only be made by the individual to whom the number is assigned.
- Performing providers *cannot* change the TIN.

Provider Demographic Information

Please review the existing information and add or modify any specific practice limitations accordingly. This will allow patients more detailed information about your practice.

General

- RightCare must have either the nine-digit Texas Provider Identifier (TPI), or the National Provider Identifier (NPI)/Atypical Provider Identifier (API), primary taxonomy code, physical address, and benefit code (if applicable) in order to process the change. Forms will be returned if this information is not indicated on the Provider Information Change Form.
- The W-9 form is required for *all* name and TIN changes.

Mail or fax the completed form to:

RightCare from Scott & White Health Plan
Attn: Provider Relations Department
MS-A4-144
1206 West Campus Drive
Temple, Texas 76502
Fax: (254) 298-3044

NOTICE: CLOSING PROVIDER PANEL

Providers who request that their panel be closed must close its panel to all Medicaid Managed Care Organizations, pursuant to the terms and conditions of the RightCare from Scott & White Health Plan Provider Agreement.