Provider Demographic Change Form

ConnectiCare

Submission date:

Complete this form if you are updating any demographic information for an individual provider or provider group. Include all information related to your request. Incomplete forms or those missing supporting documentation will not be processed.

This form must not be used for credentialing changes, contractual modifications, or adding new providers.

Current Provider Information	
Provider/Group name:	
Current tax identification number (TIN):	National provider identifier (NPI):
Contact phone:	Contact email:

Type of Change: (Check all that apply)

☐ TIN add: (MUST attach a copy of the W-9) Effective date:

☐ TIN change (current and new TINS are both required):

- ☐ Current TIN: _____
- ☐ New TIN _____ Effective date:

☐ Name change (group or provider):

☐ Hospital affiliation add/change:

☐ Open PCP panel. Effective date:	☐ Close PCP panel. Effective date: Reason:

☐ No longer accepting patients.

Location: Effective date:

_____

_____

_____

☐ Location change (complete below) ☐ Billing information change (complete below)

Primary Location Change (Please attach an additional form for each change request.)

Effective date:

Provider/Group name:

Primary/Group TIN:	Provider/Group NPI:

New primary practice location address:

Street:	
City:	
State:	ZIP:

Is this the primary mailing address? ☐ Yes ☐ No

Old primary practice location address:

Street:	
City:	
State:	ZIP:

Primary practice phone #:	Primary practice fax #:

Wheelchair accessible? ☐ Yes ☐ No ☐ N/A

Do you see patients on a regular and consistent basis, **at least one day a week**, at the above location? ☐ Yes ☐ No

Do you see patients 24 hours/seven days a week at the above location? ☐ Yes ☐ No
(If no, please list the hours of operation for each day.)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Should this location be included in the provider directory? ☐ Yes ☐ No

Payment address same as: ☐ Practice ☐ Mailing ☐ Other street address:

City:	State:	ZIP:

Mailing address same as: ☐ Practice ☐ Payment ☐ Other street address:

City:	State:	ZIP:

Mailing office phone #:	Mailing office fax #:

Secondary Location Change

Effective date:

New address:		Old address:	
Street:		Street:	
City:		City:	
State:	ZIP:	State:	ZIP:

Phone #:
Fax #:
Email:

Wheelchair accessible? ☐ Yes ☐ No ☐ N/A

Do you see patients on a regular and consistent basis, **at least one day a week**, at the above location? ☐ Yes ☐ No
Do you see patients 24 hours/seven days a week at the above location? ☐ Yes ☐ No
(If no, please list the hours of operation for each day.)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Should this location be included in the provider directory? ☐ Yes ☐ No

Billing Information Change *Note: A W-9* ***must*** *be submitted with all tax ID updates to process the request.*

Effective date:

New billing information:			Old billing information:		
Name:			Name:		
Tax ID:	NPI:		Tax ID:	NPI:	
Address:			Address:		
City:	State:	ZIP:	City:	State:	ZIP:
Telephone:			Telephone:		
Email:			Email:		

Send completed form and all supporting documents by:

- Email: **providerfileoperations@connecticare.com**
- Mail: ConnectiCare
  Network Operations
  175 Scott Swamp Road
  Farmington, CT 06032

Print Reset Form