PROVIDER DEMOGRAPHIC CHANGE FORM

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 will not be processed.

All fields marked with an asterisk (*) denotes required information.

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):
Phone:	Email:

Type of Change: (Check all that apply)

☐ Add TIN: ***(MUST attach a copy of the W-9)*** *Effective Date: _____ _____

☐ Change TIN: *Effective Date: _____ _____

☐ Change name (group or provider): _____

☐ Change/add hospital affiliation: _____

☐ Open PCP panel ☐ Close PCP panel

☐ Termination: (Check only **ONE** reason)

Code	Reason	Effective date
01	☐ Retired	
02	☐ Relocation (out of service area)	
03	☐ Death	
04	☐ No ConnectiCare IPA/PHO Affiliation	
05	☐ Contract Termination	
08	☐ Leaving current group (going to a non-participating group, starting or joining a new practice/group) *Group name:	
18	☐ Leave of absence *Expected return date:	
19	☐ Other *Reason:	

PROVIDER DEMOGRAPHIC CHANGE FORM

ConnectiCare

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**, in the above location? ☐ Yes ☐ No

Do you see patients 24 hours/7 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 #:

PROVIDER DEMOGRAPHIC CHANGE FORM

ConnectiCare

Secondary Location Change	**Effective date**
New address: Street: City: State: Zip:	Old address: Street: City: 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**, in the above location? ☐ Yes ☐ No

Do you see patients 24 hours/7 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
- Fax: 1-866-561-9260
- Mail: ConnectiCare
  Network Operations
  175 Scott Swamp Road
  Farmington, CT 06032