



# NOTIFICATION OF CHANGE FORM (NV)

EMAIL COMPLETED FORM TO: [P3NETWORKSOLUTIONS@P3HP.ORG](mailto:P3NETWORKSOLUTIONS@P3HP.ORG)

### IDENTIFY PROVIDER/MASTER VENDOR THAT HAS CHANGED

Provider Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Specialty (list all that apply):	Effective Date of Change:
Contract Name:	Citra Provider #:
Master Vendor Name:	Citra Master Vendor #:

TYPE OF REQUEST	TYPE OF PROVIDER	ADD/CHANGE
<input type="checkbox"/> Add (New Info) <input type="checkbox"/> Change (Old & New Info) <input type="checkbox"/> Termination <input type="checkbox"/> Reactivate	<input type="checkbox"/> Employed <input type="checkbox"/> Contracted <input type="checkbox"/> Letter of Agreement <input type="checkbox"/> Non-Contracted	<input type="checkbox"/> Provider Joining Group <input type="checkbox"/> Provider/Vendor Name Change <input type="checkbox"/> Group/Master Vendor Change <input type="checkbox"/> Tax Identification Number <input type="checkbox"/> Provider Practice Site/Address <input type="checkbox"/> Billing Address <input type="checkbox"/> Other Demographic <input type="checkbox"/> Provider Panel Change <input type="checkbox"/> Billing Area in IDX <input type="checkbox"/> Other-Credentialing Update

HEALTH PLANS:  BCBS  Hometown  Select

CHANGE DOCUMENTATION	OLD INFORMATION	NEW INFORMATION
1. Provider Joining Group	1.	1.
2. Provider D.O.B.	2.	2.
3. Provider SSN	3.	3.
4. Provider/Vendor Name	4.	4.
5. Group Name/Master Vendor	5.	5.
6. Tax Identification Number	6.	6.
7. Clinic Name	7.	7.
8. Provider Practice Site/Address	8.	8.
9. Provider Site Phone #	9.	9.
10. Provider Site Fax #	10.	10.
11. Referral Fax #	11.	11.
12. Billing Office Address	12.	12.
13. Billing Office Phone #	13.	13.
14. Billing Office Fax #	14.	14.
15. EMR/EHR	15.	15.
16. NPI	16.	16.
17. CAP or FFS Provider	17.	17.
18. License Number	18.	18.
19. Hospital Affiliations	19.	19.

### COMMENTS:

Provider Termed
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### CREDENTIALING/REFERRALS:

Credentialing Date: Par/Referral Status Code:	BCBS	Hometown	Select
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Submitted By:	Phone:	Email:	Date:
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### Internal Use Only

Submitted By:	Department:	Date:	Written (see attached):
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Grids:	<input type="checkbox"/> Contract	<input type="checkbox"/> Claims	<input type="checkbox"/> Master Par	<input type="checkbox"/> HSD
Directories:	<input type="checkbox"/> Hometown	<input type="checkbox"/> Select	<input type="checkbox"/> P3	
Change Notices:	<input type="checkbox"/> Internal	<input type="checkbox"/> BCBS	<input type="checkbox"/> Hometown	<input type="checkbox"/> Select