NOTIFICATION OF CHANGE

EMAIL FORM TO: PROVIDERRELATIONS@P3HP.ORG

IDENTIFY PROVIDER/MASTER VENDOR THAT HAS THE CHANGE

Provider Name(s): ☐ Male ☐ Female	
Specialty (list all that apply):	Effective Date of Change:
Contract Name:	Citra Provider #:
Master Vendor Name:	Citra Master Vendor #:

TYPE OF REQUEST

- ☐ Add (New Info)
- ☐ Change (Old & New Info)
- ☐ Termination
- ☐ Reactivate (claims use only)

TYPE OF PROVIDER

- ☐ Employed
- ☐ Contracted
- ☐ Letter of Agreement
- ☐ Non Contracted

ADD/CHANGE

- ☐ Provider Joining Group
- ☐ Provider/Vendor Name Change
- ☐ Group/Master Vendor Change
- ☐ Tax Identification Number
- ☐ Provider Practice Site/Address
- ☐ Billing Address
- ☐ Other Demographic
- ☐ Provider Panel Change
- ☐ Billing Area in IDX
- ☐ Other- Credentialing Update

Board Certified ☐ Y ☐ N ☐ N/A

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 SS#	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. NPI	15.	15.
16. CAP or FFS Provider	16.	16.
17. License Number	17.	17.
18. Hospital Affiliations	18.	18.

COMMENTS:

CREDENTIALING/REFERRALS:

	BCBS	Hometown	Select
Credentialing Date:			
Par/Referral Status Code:			

Contracting Dept Use Only: ☐ Verbal Name: Date: ☐ Written (see attached)

Submitted By: Phone: Dept: Today's Date:

Grids:	☐ Contract	☐ Claims	☐ MasterPar	☐ HSD
Directories:	☐ Hometown	☐ Select	☐ P3	
Change Notices:	☐ Internal	☐ BCBS	☐ Hometown	☐ Select