



# Change Form

Please list only the information that is being changed, old and new. Submit one form for each provider being changed. If you need to terminate from a group because you are joining a new group, please complete a new HCAS Form for the new group.

- Type of Request:**
- Change provider information
  - Change to affect multiple providers/locations
  - Provider Termination (see next form that follows)

Individual/ Facility NPI	_____
Tax ID	_____
Effective date	_____

(list of affected providers attached)

## Demographic Information

Current	New
Provider/Group Name: _____	Provider/Group Name: _____
Individual/Facility NPI: _____	Individual/Facility NPI: _____
Practice Address:	Practice Address:
Line 1: _____	Line 1: _____
Line 2: _____	Line 2: _____
City: _____	City: _____
State: MA _____ Zip: _____	State: MA _____ Zip: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____
Remit Address:	Remit Address:
Line 1: _____	Line 1: _____
Line 2: _____	Line 2: _____
City: _____	City: _____
State: MA _____ Zip: _____	State: MA _____ Zip: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

## Tax Information - Please attach a copy of the W-9 when making changes

Tax ID: _____	Tax ID: _____
TIN name: _____	TIN name: _____

## Additional Provider Information

<b>Office hours:</b> Mon _____ Fri _____ Tue _____ Sat _____ Wed _____ Sun _____ Thur _____	<b>Disabled access?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Accessible via public transportation <input type="checkbox"/> Elevators in multistory buildings <input type="checkbox"/> Handicap accessibility <input type="checkbox"/> Wheelchair ramps <input type="checkbox"/> Handicap parking available <input type="checkbox"/> Handicap parking accessible bathrooms
Patient Ages: _____ to _____ Language(s) spoken in addition to English: _____ School Based Health Center: _____ PCP coverage information (Attach addtl sheet if needed)	Patient Ages _____ to _____

<b>Hospital affiliations:</b> <b>Contract and Payment information</b> PCP? _____ PCP panel status: _____ Hospitalist _____	<b>Provider Specialties</b> Specialty: _____ Subspecialty: _____ Specialty: _____ Subspecialty: _____ Additional specialties: _____
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## Termination

**Please complete Provider Termination Notification Form that follows.**

Form completed by (name, title): _____
Form completed date: _____
Mailing contact name and email address: _____
<b>Internal Use Only</b>
PPC Rep making change: _____
Date change completed: _____

[Click here to send via e-mail and please don't forget to send secure](#)  
 or  
 Fax to (617) 897- 0818

**Send to:** Provider Processing Center  
 Boston Medical Center HealthNet Plan  
 Two Copley Place, Suite 600  
 Boston, MA 02116



# Provider Termination Notification Form

30 day notice required\*

Provider Name:	
Provider NPI:	
Entity Name:	
Entity TIN:	
Termination Effective Date: * BMC HealthNet Plan will use today's date as the termination date if the date is in the past.	
Termination Reason:	
Will provider still practice in Massachusetts? (Y/N)	
If PCP, who will assume the patient panel? Is provider within the same group? Name/TIN:	
Name/title of person completing this form (please print):	

As a result of this provider terminating from the BMC HealthNet Plan provider network, the following steps will take place.

- 1) Provider will be terminated from the BMC HealthNet Plan provider network upon receipt.
  - a. Received Date to be used as the termination date; Future Date will be used if requested.
- 2) Provider will not be able to bill (or be reimbursed) for claims with a date of service after the provider's termination date.
- 3) For primary care providers:
  - a. Any patient who is currently assigned to this provider will be notified about their PCP terminating from the BMC HealthNet Plan provider network.
  - b. Notices will go out to each patient within 15 days of this notification.
  - c. Panel will be re-assigned accordingly.
- 4) For specialist providers:
  - a. Any patient who has seen this provider within the past 12 months will be notified about this specialist leaving the BMC HealthNet Plan provider network.
  - b. Notices will go out to each patient within 15 days of this notification.

I understand that BMC HealthNet Plan will take the above steps.

Signature of Acknowledgement: \_\_\_\_\_

I certify that I am authorized to submit this type of communication.

Submit via email to:	BMCHP.ProviderProcessingCenter@bmchp.org
Submit via fax to:	617-897-0818
Contact your BMC HealthNet Plan Provider Relations representative. Or, if unknown, send email to:	provider.info@bmchp.org

\* 30 Day Notice of Termination is standard, but some contracts may have a 60 day requirement.

\*\* Form is to be returned within 7 days. Provider will be terminated in 7 days even if you fail to return this form in a timely manner.