Change Termination Form

bmchp.org | 888-566-0008

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.

Provider Information
INDIVIDUAL/FACILITY
NPI
TAX ID
EFFECTIVE DATE

(List of affected providers attached)

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

Demographic Information	
Current	**New**
PROVIDER/GROUP NAME	PROVIDER/GROUP NAME
INDIVIDUAL/FACILITY NPI	INDIVIDUAL/FACILITY NPI
PRACTICE ADDRESS (CURRENT)	**PRACTICE ADDRESS (NEW)**
CITY	CITY
STATE	STATE
ZIP CODE	ZIP CODE
PHONE NUMER	PHONE NUMER
FAX NUMBER	FAX NUMBER
REMIT ADDRESS (CURRENT)	**REMIT ADDRESS (NEW)**
CITY	CITY
STATE	STATE

ZIP CODE (CURRENT)	ZIP CODE (NEW)
PHONE NUMBER (CURRENT)	PHONE NUMBER (NEW)
FAX NUMBER (CURRENT)	FAX NUMBER (NEW)

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

TAX ID (CURRENT)	TAX ID (NEW)
TIN NAME (CURRENT)	TIN NAME (NEW)

Additional Provider Information

OFFICE HOURS

MON.	TUES.	WED.	THURS.

FRI.	SAT.	SUN.

DISABLED ACCESS?

Yes No

Accessible via public transportation	Handicap accessibility	Handicap parking available
Handicap parking accessible bathrooms	Elevators in multistory buildings	Wheelchair ramps

PATIENT AGES

______________ to ______________ ______________ to ______________

Languages Spoken in Addition to English	School Based Health Center
PCP Coverage Information (Attach additional sheet if needed)	Hospital Affiliations

Contract and Payment Information	Provider Specialties	
PCP?	SPECIALTY	SUBSPECIALTY
PCP PANEL STATUS	SPECIALTY	SUBSPECIALTY
HOSPITALIST	ADDITIONAL SPECIALTIES	

Termination – Please complete Provider Termination Notification Form that follows.

FORM COMPLETED BY (NAME, TITLE)	FORM COMPLETED DATE

MAILING CONTACT NAME	MAILING CONTACT EMAIL ADDRESS
Internal Use Only	
PPC REP MAKING CHANGES	DATE CHANGE COMPLETED

Submit via Mail:

Provider Processing Center

Boston Medical Center HealthNet Plan

Schrafft's City Center

529 Main Street, Suite 500

Charlestown, MA 02129

Submit via Email: BMCHP.ProviderProcessingCenter@bmchp.org

Submit via Fax: 617-897-0818

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Provider Termination Change Form
30 Day Notice Required*

PROVIDER NAME	PROVIDER NPI
ENTITY NAME	ENTITY TIN
TERNMINATION EFFECTIVE DATE **BMC HealthNet Plan will use today's date if the date is in the past*	TERNMINATION REASON
Will provider still practice in Massachusetts? Yes No	
If PCP, who will assume the patient panel?	Is provider within the same group?
NAME OF PROVIDER ASSUMING PATIENT PANEL	TIN
NAME OF PERSON COMPETING FORM	TITLE OF PERSON COMPLETING FORM

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 Acknowledgment: ____

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

Submit via Email: BMCHP.ProviderProcessingCenter@bmchp.org

Submit via Fax: 617-897-0818