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)

(list of affected providers attached)

Individual/ Facility NPI	
Tax ID	
Effective date	

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

Office hours:

Mon		Fri	
Tue		Sat	
Wed		Sun	
Thur			

Disabled access? ☐ Yes ☐ No
- ☐ Accessible via public transportation
- ☐ Elevators in multistory buildings
- ☐ Handicap accessiblility
- ☐ Wheelchair ramps
- ☐ Handicap parking available
- ☐ Handicap parking accessible bathrooms

Patient Ages: _____ to _____ Patient Ages _____ to _____

Language(s) spoken in addition to English:

School Based Health Center:

PCP coverage information (Attach addtnl sheet if needed)

Hospital affiliations:

Contract and Payment information

PCP?

PCP panel status:

Hospitalist

Provider Specialties

Specialty: _____ Subspecialty: _____

Specialty: _____ Subspecialty: _____

Additional specialties:

Termination

Please complete Provider Termination Notification Form that follows.

Form completed by (name, title):	
Form completed date:	
Mailing contact name and email address:	
Internal Use Only	
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

Jan-12

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.

January-12