

PROVIDER UPDATE AND CHANGE FORM



This form should be used when changing a Marketplace contracted practitioner or provider name, location, phone or fax number, billing or email address, and office hours. Please email or mail to CCHP.

- Email to: cchp-providerupdates@chw.org
- Mail to: CCHP Provider Relations
P.O. Box 1997, MS 6280
Milwaukee, WI 53201-1997

Effective date of change: _____ Type of change: _____

SECTION 1: OLD INFORMATION (Note: Changes for practitioners and/or providers through a group must be submitted by the group.)

NAME OF ORGANIZATION (INCLUDE LEGAL NAME DOING BUSINESS AS)		FEDERAL TAX ID NUMBER	GROUP NPI 2
			INDIVIDUAL NPI
PHYSICAL ADDRESS			
STREET ADDRESS		CITY	STATE ZIP
PHONE NUMBER		FAX NUMBER	
MAILING ADDRESS			
STREET ADDRESS		CITY	STATE ZIP
PHONE NUMBER		FAX NUMBER	
BILLING ADDRESS			
ADDRESS		CITY	STATE ZIP
PHONE NUMBER		FAX NUMBER	

SECTION 2: NEW INFORMATION (Only complete all the fields of item that has changed.)

NAME OF ORGANIZATION (INCLUDE LEGAL NAME DOING BUSINESS AS)		FEDERAL TAX ID NUMBER (TIN)	GROUP NPI 2
			INDIVIDUAL NPI
PHYSICAL ADDRESS <input type="radio"/> UNCHANGED			
STREET ADDRESS		CITY	STATE ZIP
PHONE NUMBER		FAX NUMBER	
MAILING ADDRESS <input type="radio"/> UNCHANGED <small>(ONLY COMPLETE IF YOU'RE NOT ABLE TO ACCEPT MAIL AT YOUR PHYSICAL ADDRESS)</small>			
STREET ADDRESS		CITY	STATE ZIP
PHONE NUMBER		FAX NUMBER	
BILLING ADDRESS <input type="radio"/> UNCHANGED			
ADDRESS		CITY	STATE ZIP
PHONE NUMBER		FAX NUMBER	

SECTION 3: PERSON COMPLETING FORM

NAME OF ORGANIZATION YOU REPRESENT		TITLE	
STREET ADDRESS		CITY	STATE ZIP
PHONE NUMBER		EMAIL ADDRESS	

SECTION 4: ROSTER OF PRACTITIONERS / PROVIDERS PRACTICING WITH GROUP (IF NEED MORE ROOM, ATTACH SEPARATE ROSTER SHEET)

	ACCEPTING NEW PATIENTS?		ACCEPTING NEW PATIENTS?
FULL NAME	<input type="checkbox"/> YES <input type="checkbox"/> NO	FULL NAME	<input type="checkbox"/> YES <input type="checkbox"/> NO
FULL NAME	<input type="checkbox"/> YES <input type="checkbox"/> NO	FULL NAME	<input type="checkbox"/> YES <input type="checkbox"/> NO
FULL NAME	<input type="checkbox"/> YES <input type="checkbox"/> NO	FULL NAME	<input type="checkbox"/> YES <input type="checkbox"/> NO

IN ADDITION TO ENGLISH, WHAT LANGUAGES DO YOU SPEAK IN YOUR OFFICE? SPANISH HMONG OTHER: _____

SECTION 5: HOURS OF OPERATION (EXAMPLE: 8 a.m.)

MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		SUNDAY	
OPEN	CLOSE	OPEN	CLOSE	OPEN	CLOSE	OPEN	CLOSE	OPEN	CLOSE	OPEN	CLOSE	OPEN	CLOSE
REGULAR		REGULAR		REGULAR		REGULAR		REGULAR		REGULAR		REGULAR	
URGENT CARE		URGENT CARE		URGENT CARE		URGENT CARE		URGENT CARE		URGENT CARE		URGENT CARE	

SECTION 6: FEDERAL TAX ID NUMBER (TIN) CHANGES

Changes in a tax ID number or name require you to submit a W-9 form or IRS letter (SS4 or 147C). Please attach to this form and email to: chcp-contracting@chw.org. (To email, file size not to exceed 4MB & types accepted: .doc; .docx; .rtf; .xls; .pdf.)

Did you attach supporting documents? YES NO

SECTION 7: BEHAVIORAL HEALTH PROVIDER INFORMATION

If you're a Behavioral Health provider, please answer the following questions:

- Do you provide home visits?** YES NO
- Are you able to schedule a patient visit within seven days of discharge from an inpatient facility?** YES NO
- Do you provide day treatment?** YES NO

SECTION 8: EMAIL ADDRESS CHANGE

ORGANIZATION NAME(S) ASSOCIATED WITH THIS EMAIL ADDRESS	
OLD EMAIL ADDRESS	NEW EMAIL ADDRESS

COMMENTS:

Interpreter Services

Children's Community Health Plan (CCHP) complies with all applicable civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, disability, or other legally protected status, in its administration of the plan, including enrollment and benefit determinations.

If someone you're helping has questions about Together with CCHP, they have the right to get help or information in their language at no cost.

- To talk to an interpreter, call **1-844-201-4672**.
- If you or the Together with CCHP member is hearing impaired, call **1-844-531-4856**.

SPANISH: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Together with CCHP tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-201-4672.

HMONG: Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Together with CCHP, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-844-201-4672.



with  Children's
Community Health Plan

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togetherCCHP.org