Provider Information Change Request

The information provided on this form is required for claims processing and directory listings.

Note:
Please use separate forms for additional practice locations or practitioners/organizations.

☐ Credential new provider
☐ Change information
☐ Add provider to new/additional location
☐ Add provider at hospital-based location only[1]
☐ Termination

Practice Name _____
Effective date at your organization _____
TIN # _____
Reason _____
Date _____

1. Provider information (name as shown on CMS 1500 field 31 or UB box 1)

☐ Organizational provider ☐ Individual Practitioner (PCP) ☐ Individual Practitioner (Specialist)

Name _____ ☐ Male ☐ Female NPI _____ Degree _____

Lines of Business & Tier (1,2 or 3): ☐ Medicaid – Tier ___ ☐ CHP + Tier ___ ☐ Medicare – Tier ___ ☐ Elevate – Tier ___ ☐ Commercial – Tier ___

2. Practice location information (for patient visits and directory listing)

Practice name (as it should appear in directories) _____

Address _____

City _____ State _____ Zip _____ County _____

Practitioner specialty (as practicing at this location) _____

List this location in directories? Note: hospital-based locations will not be listed. ☐ Yes ☐ No

Location NPI _____ Tax ID number (attach matching IRS W9) _____

Practice contact name _____ Practice contact email _____

Practice contact phone _____ Practice contact fax _____

3. Billing information (as listed on CMS 1500 field 33 or UB box 2)

Billing name (as it appears on claims) _____

Address _____

City _____ State _____ Zip _____ County _____

Billing contact name _____ Billing contact email _____

Billing contact phone _____ Billing contact fax _____

Credentialing contact name _____ Credentialing contact email _____

Credentialing contact phone _____ Credentialing contact fax _____

4. Summary of changes/notes

_____

_____

Form completed by _____

Email _____ Phone _____

Hospital-based providers *are those who practice exclusively in an in-patient setting; a credentialing application is not required.*

Mail: Denver Health Medical Plan, 777 Bannock Street, Denver, CO 80204

Phone: Elevate Child Health Plan Plus (CHP+): 1-800-700-8140, DHHA: 1-800-700-8140
Elevate Medicare Advantage: 1-877-956-2111 TTY 711, Elevate Exchange/CO Option: 1-855-823-8872, Elevate Medicaid Choice: 1-855-281-2418

Fax: 303-602-2138 Email: ManagedCare.ProviderRelations@dhha.org