Parkland Community Health Plan

Provider Action Form

Complete this form to update PCHP network provider information. Email to PCHPProviderInfoUpdate@phhs.org

Action *Please check one or more as appropriate*		Effective Date
☐ Medicaid/TPI # Change for Service Location	☐ Provider Directory Changes	
☐ Medicaid/TPI # Change for Individual Provider	☐ Term Provider	
☐ Change Address / Phone (Billing / Mailing / Remit) *Attach W9*	☐ Remove Provider from Service Location	
☐ Change Address / Phone (Physical Service Location)	☐ Other *(please explain)* :	
☐ Add Address / Phone (Physical Service Location)		

Tax ID Add/Change? Email PCHP.ContractingDepartment@phhs.org.
Add Provider to existing contact or to Join PCHP? Complete the Prospective Provider Form and email to PCHP.ContractingDepartment@phhs.org.

Provider Information

Last Name	First Name	MI	Degree
Provider NPI #	**DOB**	**Provider Specialty**	**Practice as:** ☐ PCP ☐ Specialist
License #	**Tax ID #**	**Medicaid/TPI #**	

Physical Service Location

Service Location Name:	Service Location Website	Service Location Email

Street Address			
City	**State**	**Zip Code**	**County**
Phone	**Fax**	**Handicap accessible?** ☐ Yes ☐ No	

Billing / Mailing / Remit Information

Billing Name Information				Group TIN
Street Address				**Group NPI #**
City	**State**	**Zip Code**	**County**	**Medicaid/TPI #**
Phone	**Fax**	**Billing Email**		

Provider Term

Term Reason	Assign Members to New Provider: Name
Name of New Service Location for Members	**Assign Members to New Provider: NPI**

Provider Directory

Gender Restrictions	Language Update	Appear in Directory	Accepting New Members
		☐ Yes ☐ No	☐ Yes ☐ No

Age Range	Telemedicine	Office hours for specified service location above:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	☐ Yes ☐ No								

Additional Comments

Requestor Name	Date	Phone	Email

Please submit to **PCHPProviderInfoUpdate@phhs.org**