

HEALTHPLUS OF MICHIGAN PROVIDER RECORDS CHANGE FORM

The purpose of this form is to document business record changes requested by HealthPlus participating providers. In order to ensure accuracy of our provider record database for claims reimbursement, mailings, etc., HealthPlus requires requested record changes be submitted in writing using the provider form below. The form will serve as documentation for change requests. Completion of the form will serve as an audit source for HealthPlus to verify all key record elements related to a provider's participating status with HealthPlus.

In order for the request to be approved, the necessary change information needs to be complete. Other than required information which is indicated with an asterisk, only the information that needs to be changed will need to go on this form. The requested change will not be entered into the HealthPlus provider record database until all changed information fields on the form are completed and supporting documentation is received. Please fax completed form to: (810) 230-2081.

*Requestor Name _____ *Phone # _____ *Fax # _____

Provider Completion Section: Independent Employed/Facility Associated Contracted

	Current information in the HealthPlus system	New information provider wants in HealthPlus system
*Provider name including degree (MD/DO)		
*Provider ID #		
Group name		
Group Provider ID #		
Specialty		
Hospital name		
PHO affiliation		
Physical office location(s) for this provider		
Physical office phone #		
Physical office fax #		
<i>Pay To</i> name		
<i>Pay To</i> address for this provider #		
Billing phone #		
Billing fax #		
*Tax ID #		
Is <i>billing</i> address the same as W-9 address? If not indicate W-9 address (Please attach W9 or Form 8109)		
DEA #		
Medicare #		
Medicaid #		
License #		
NPI#		
Accept status change		
*Effective date of this change		

Notes:

*Required field

Additional Location New Location Term Old Location Move Location

Line of Business	All _____ Comm/Options _____ PPO _____ HP/SM _____ M+C _____ SHP _____ BHP _____ GHP _____
PPG #	From _____ To _____
Risk Withhold %	From _____ To _____
AMISYS	
PPG System	

HEALTHPLUS PROVIDER CHANGE FORM DIRECTIONS

Please print all information on the change form

FORM FIELD NAME	DIRECTIONS
Provider name including degree (MD/DO)	Enter the first name, middle initial, and last name of the provider the change is for (e.g., Jane R. Smith, M.D.)
*Provider ID #	HealthPlus assigns a provider ID # to each provider. Place your HealthPlus provider ID # here. If you do not know the provider ID #, please contact Customer Service at 1-800-332-9161.
Group name	If the provider is part of a group and the group bills HealthPlus using the tax ID # used to complete this form, indicate the group name here. Please indicate the full group name, such as ABC Radiology, Inc.
Group Provider ID #	If you do not know the provider ID #, please contact Customer Service at 1-800-332-9161.
Specialty	Indicate the provider's specialty here (e.g., cardiology).
Hospital name	List the hospital(s) name(s) that the provider is affiliated with here. Provider can be affiliated with more than one hospital.
PHO affiliation	List the provider's PHO(s) affiliation(s) name here (e.g., Genesys PHO). Provider can be affiliated with more than one PHO.
Physical office location(s) for this provider	List each physical location associated with the provider # or group # here. Include building #, street name, suite #, city, state and zip code. This cannot be a P.O. Box – we use these locations in our provider directory.
Physical office phone #	List each physical location's 10 digit phone # here. This is the phone # that will be listed in our provider directory (e.g., (989) 123-4567)
Physical office fax #	List the 10 digit fax # for each physical location (e.g., (989) 123-4567)
<i>Pay To</i> name	List the name associated to the Tax ID # indicated on this form.
<i>Pay To</i> address for this provider # (same as billing address)	List the billing address for the Tax ID # indicated on this form. Include building #, street name, suite #, city, state and zip code.
Billing phone #	List the telephone # that the HealthPlus Billing Department would call with questions.
Billing fax #	List the fax # that the HealthPlus Billing Department would fax any paperwork to.
*Tax ID #	List the Tax ID # here. If the Tax ID # is changing for the provider or group, a W9 must accompany this change request.
Is <i>billing</i> address the same as W-9 address? If not indicate W-9 address (Please attach W9 or Form 8109)	Is billing address same as W-9 address? If not, please indicate address.
DEA #	List the provider's DEA # here
Medicare #	List the provider's Medicare ID # here
Medicaid #	List the provider's Medicaid ID # here
License #	List the provider's State of Michigan License # here
NPI #	
Accept status change	
*Effective Date of This Change	Indicate the six digit date the change is effective (e.g., 060110 = June 1, 2010)