Genesee Health Plan
Your Plan for *Better Health*

PROVIDER CHANGE REQUEST FORM

Please document any requested changes below, sign and return form with W-9

Provider Type: ☐ Primary Care ☐ Specialist ☐ Allied Health ☐ Ancillary

Degree: ☐ MD ☐ DO ☐ DPM ☐ OD ☐ PA ☐ NP ☐ OTHER

PHYSICIAN INFORMATION

Name (last, first, middle initial):

NPI Number: ☐ Male ☐ Female

CAQH ID Number:

Specialty:

Does your practice participate in Medicare? ☐ YES ☐ NO **Medicaid?** ☐ YES ☐ NO

If Primary Care, accepting new patients? ☐ YES ☐ NO

Joining Existing Practice? ☐ YES ☐ NO *If yes, name of practice:*

PRIMARY OFFICE INFORMATION

Contact Person: **Email:**

Street address: **Suite #:**

City: **State:** **Zip:**

Office Phone: **Fax:**

Hospital System Affiliation: ☐ McLaren Flint ☐ Hurley ☐ Ascension Genesys ☐ Other:

BILLING INFORMATION

Bill To Name: **Billing Contact Person:**

Billing street address: **Suite #:**

City: **State:** **Zip:**

Office Phone: **Fax:** **Email:**

Tax ID Number: **Current W-9 included?** ☐ Yes ☐ No

CONSENT AND AUTHORIZATION

By signing this form, I affirm that the information provided is true and accurate to the best of my knowledge. Any incomplete or misstatements could result in denial of contracting. I also authorize GHP to access physician information from the Council of Affordable Quality Healthcare (CAQH) Proview database.

Signature:_____ Date:_____

Printed name:_____ Title:_____