

Provider Change Form



- ✓ Submit one Provider Change Form (PCF) per TIN. Do not submit changes for multiple TINs.
- ✓ The preferred method for completing the PCF is electronically. Hand written changes may result in delayed or inaccurate processing.
- ✓ Please be sure to update you CAQH application as well; your CAQH must be updated separately.
- ✓ Return PCF to www.magnoliahealthplan.com/providers/resources/behavioral-health

What change do you need to make?	Steps to Complete:
<input type="checkbox"/> Change/add/delete primary address, email, telephone, and/or fax number	<ul style="list-style-type: none"> ✓ Complete SECTION A ✓ Complete SECTION B
<input type="checkbox"/> Change/add/delete secondary address, telephone, and/or fax number	<ul style="list-style-type: none"> ✓ Complete SECTION A ✓ Complete SECTION B
<input type="checkbox"/> Change of billing address, telephone, and or fax number	<ul style="list-style-type: none"> ✓ Complete SECTION A ✓ Complete SECTION C
<input type="checkbox"/> Change of mailing address, telephone, and or fax number	<ul style="list-style-type: none"> ✓ Complete SECTION A ✓ Complete SECTION D
<input type="checkbox"/> Change Taxonomy	<ul style="list-style-type: none"> ✓ Complete SECTION A ✓ Complete SECTION E
<input type="checkbox"/> Change of provider status (e.g. moved out of area, capacity changes, etc.)	<ul style="list-style-type: none"> ✓ Complete SECTION A ✓ Complete SECTION F
<input type="checkbox"/> Change Medicaid Number	<ul style="list-style-type: none"> ✓ Complete SECTION A ✓ Complete SECTION G
<input type="checkbox"/> Discontinue Behavioral Health Services	<ul style="list-style-type: none"> ✓ Contact your Provider Relations Rep <i>Visit www.magnoliahealthplan.com/providers to locate your Rep's contact information</i>
<input type="checkbox"/> Adding/changing TIN	<ul style="list-style-type: none"> ✓ Contact your Provider Relations Rep <i>Visit www.magnoliahealthplan.com/providers to locate your Rep's contact information</i>

SECTION A REQUIRED INFORMATION

 Solo Practitioner

 Group/Clinic

Today's Date		Effective Date of Change	
Last Name	First Name	M.I.	Individual NPI
Individual Medicaid Number	Individual Medicare Number	Phone	
Group/Clinic Name as it appears on W9 (if applicable)		TIN	Taxonomy
Provider Email	Credentialing Contact Name	Credentialing Contact Email	

SECTION B CHANGE IN LOCATION INFO

- Update current location
 Add new location
 Delete this location*
 This is the primary location
 This is a secondary location
 DO NOT Display in Directory

If the Updated/New practice location below is also the Billing address please also fill out SECTION C

NOTE: Must be a street address (not a PO Box)

Previous/Discontinued Practice Location				Updated/New Practice Location			
Group Display Name				Group Display Name			
Group NPI		Group Medicaid #		Group NPI		Group Medicaid #	
Address			Taxonomy	Address			Taxonomy
City		ST	Zip	City		ST	Zip
County	Phone		Fax	County	Phone		Fax
Contact Person				Contact Person			
Contact Email				Contact Email			

**Please provide a reason for deleting this location:*

- I. This location change affects: Just the individual practitioner in SECTION A
 All practitioners associated with this Group
**Please fill out ATTACHMENT H of this form*

- II. Does this location have handicap accessibility? Yes No

- III. Does this location have any limitations or restrictions?

Gender: Male Female
Age: Beginning at: Ending at: All ages accepted

- IV. Please list up to two languages other than English provided at this location:

1) 2)

- V. Is this location currently accepting new patients? Yes No

- VI. Office Hours:

Monday	Open:	Close:	Tuesday	Open:	Close:
Wednesday	Open:	Close:	Thursday	Open:	Close:
Friday	Open:	Close:	Saturday	Open:	Close:
Sunday	Open:	Close:	<input type="checkbox"/> By Appt Only		<input type="checkbox"/> 24/7

SECTION C CHANGE IN BILLING ADDRESS OR BILLING INFO

This Billing address change affects:

- Just the individual practitioner in SECTION A
 All practitioners associated with this Group
**Please fill out ATTACHMENT H of this form*

<input type="checkbox"/>	Please update my 1099 Address <i>(a new W-9 is required. Please include a new W-9 with your submission)</i>		
Provider Name as it appears on W9		TIN	Medicaid Number
New Billing Address			
Phone		Fax	
Contact Person		Contact Email	

SECTION D CHANGE IN MAILING ADDRESS

This Mailing address change affects:

- Just the individual practitioner in SECTION A
 All practitioners associated with this Group
**Please fill out ATTACHMENT H of this form*

Provider Name or Group/Clinic Name (if applicable)			
New Mailing Address			
Phone		Fax	
Contact Person		Contact Email	

SECTION E CHANGE IN TAXONOMY

- Individual in SECTION A Group

Current Taxonomy	Current Taxonomy Description
New Taxonomy	New Taxonomy Description

SECTION F CHANGE OF PROVIDER STATUS

Please select from drop down menu:

SECTION G CHANGE IN MEDICAID NUMBER

- Individual in SECTION A Group

Current/Old Medicaid #:	New Medicaid #:
Effective Date of Change:	Reason for Change:

All changes on this form, where indicated to affect all practitioners associated with group, will be applied to all **Magnolia Health** credentialed practitioners listed below:

First Name	Last Name	NPI	Section/s of PCF changes that are applicable

Feel free to use the space below if you would like to further describe the changes that you are needing to make:

Signature

Date

Name

Title

Submit your PCF by uploading to
www.magnoliahealthplan.com/providers/resources/behavioral-health