Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Provider Change Form

Group Name:	TIN:
Provider Name:	Provider NPI:

1. Type Of Change (Check all that apply)

☐ Name change (Please fill out part 3. Demographic change)	☐ Phone Number Change	Changing from: ☐HMFP to API ☐API to HMFP ☐ Other _____
☐ Address	☐ Status Change: PCP ☐ Status Change: SCP ☐ Status Change: PCP/SCP	☐ Panel change Open
☐ Tax ID*	☐ Adding a Practice Location	☐ Panel change Close
☐ Other		

***W9 required for billing changes**

2. Address Information:

New/Additional Address	**Old Addresses**
Address Type: ☐ Primary ☐Secondary ☐ Billing ☐ Mailing	Address Type: ☐ Primary ☐Secondary ☐ Billing ☐ Mailing
Address line1:	Address line1:
Address line 2:	Address line 2:
City:	City:
State: Zip:	State: Zip:
Phone:	Phone:

3. Demographic Change – 30 day notice required

Effective date:

☐ New provider name: Last Name:_____ First Name_____	☐ Old provider name: Last Name:_____ First Name:_____

4. Patient Panel:

☐ Panel Change Open_____ Close____ Effective Date_____

*Please be aware all panels will be open or closed with all contracted payers

5. Contact Person Submitting Information

Name:	Title:
Phone:	
Signature:	Date of submission:

Please send all Termination Requests to:* *WINHOSP_WinPHOEnrollmentTeam@lahey.org