Provider Change Form

Please complete this section for all changes listed below:

Today's Date:	Effective Date of Change:
Facility of Provider Legal Name:	
DBA or Clinic Name (if applicable):	
Tax ID:	Medicaid ID:
Group NPI:	Taxonomy #:
Individual NPI:	Facility Accreditation:
Licensure:	Contact Person Name:
State of Licensure:	Contact Person Email:
	Contact Person Phone:

Section A: CHANGE IN PHYSICAL ADDRESS, PHONE OR FAX

NOTE: Physical location will be included in the provider directory; therefore, it must be a street address (not a PO Box)

Previous Practice Location:	New Practice Location:
Facility/Provider Name:	Facility/Provider Name:
Address:	Address:
County:	County:
Phone #:	Phone #:
Fax:	Fax:
Contact Person:	Contact Person:
Email Address:	Email Address:
Medicaid #:	Medicaid #:
☐ Should we term this address?	If the previous address no longer exists, please check the box on left

Section B: CHANGE or ADDITION OF A SECOND LOCATION, ADDRESS, PHONE OR FAX

NOTE: Does the Tax ID information change for this location? ☐YES ☐NO

If yes, contact Oklahoma Complete Health Contracting Department at 1-855-688-6589

Facility/Provider Name:	
Second Location Address:	
County:	
Medicaid #:	
Phone #:	Fax:
Contact Name:	Contact email:

Office Hours at this location? ☐ Open 24 hours – or complete hours of operation below:

MON	TUES	WED	THURS	FRI	SAT	SUN

Section C: CHANGE IN BILLING ADDRESS OR BILLING INFORMATION

Facility/Provider Name:	
New Billing Address:	
Phone #:	Fax #:
Tax ID:	Medicaid #:
Exact name reported to the IRS for this Tax ID:	
Contact Name:	Contact Email:

Section D: CHANGE IN MAILING ADDRESS

Facility/Provider Name:	

New Mailing Address:	
Phone #:	Fax #:
Contact Name:	Contact Email:

Section E: CHANGE OF PROVIDER STATUS

Date change is effective: _____

Type of change (i.e. retiring, terming from Oklahoma Complete network, addition of accreditation – please include a copy of the accreditation certificate, closing of a location):

Explanation of the change: _____

_____

Section F: ADDITION or CHANGE OF AN NPI OR SERVICE

New Service(s) being added:	
New NPI:	Effective Date:
Address:	
	Medicaid ID:
County:	Taxonomy #:
Phone Number:	Licensure:
Fax Number:	State of Licensure:
Contact Name:	Contact Email:

Explanation of the change: _____

_____

Signature: _____ Date: _____