Provider Change Form Instructions

Please reference the table below before completing this form. Please attach all applicable forms required for your change. Please use one form per change.

Facility/Provider = hospital, group, FQHC, RHC, etc.
Practitioner = MD, DO, ARNP, or other individual that works within a Facility/Provider location

EFFECTIVE DATE OF CHANGE

Changes must be received at least 30 days in advance so that the change may be made prior to a provider or practitioner seeing Iowa Total Care members.

Change Type	Documents Required	Instructions
I have a facility name and TIN change **I have a facility name or TIN change**	A change to the facility name and/or a change in the TIN requires a contract amendment to the Participating Provider Agreement. An updated W9 will be required.	A request for an amendment may be made by going to: https://www.iowatotalcare.com/providers/become-a-provider/contract-request-form.html check amendment and fill out the information requested. A comment may be added to the comment box to indicate what change you are requesting.
I wish to add another NPI and Service	New Credentialing Application is required. Facility/Provider's NPI must be enrolled with IME prior to adding the service. In your email to Iowa Total Care please explain the change that you are looking to make.	Please complete and return all required documents listed in the **Facility/Ancillary Provider Application.** The credentialing application can be found on our website: https://www.iowatotalcare.com/providers/resources/forms-resources.html The completed form and attachments should be submitted to: Networkmanagement@IowaTotalCare.com
I wish to change the current NPI and/or Service or end a Service (ending a Service may be done without terming the agreement)	New Credentialing Application is required. Facility/Provider's NPI must be enrolled with IME prior to adding the service. In your email to Iowa Total Care please explain the change that you are looking to make.	Please complete and return all required documents listed in the **Facility/Ancillary Provider Application.** The credentialing application can be found on our website: https://www.iowatotalcare.com/providers/resources/forms-resources.html The completed form and attachments should be submitted to: Networkmanagement@IowaTotalCare.com
Practitioner Add/Term/Change	**Adds:** Roster ***or*** Practitioner Data Form **Changes:** Provider Change Form **Section E – OTHER CHANGES** **Terms:** Roster or Provider Change Form **Section E – OTHER CHANGES**	Please submit practitioner additions or terms on the approved Iowa Total Care roster Excel form or Practitioner Data Form. To request a roster form or Practitioner Data Form, please visit the Iowa Total Care website at: https://www.iowatotalcare.com/providers/resources/forms-resources.html or email Networkmanagement@IowaTotalCare.com
I have a Practitioner with a name change	Provider Change Form **and** Legal documents such as updated Medical License and updated DEA –if available **Section E – OTHER CHANGES**	Please complete and email both documents to Iowa Total Care at: Networkmanagement@IowaTotalCare.com
I wish to add/update an address – TIN is not changing	Provider Change Form For billing address changes please also submit an updated W9. Provider Accessibility (PAI) Survey must be completed for each service location: ttps://www.iowatotalcare.com/providers/contracting---credentialing/improving-accessibility.html	Please complete one of the following: **Section A – change physical address** **Section B – change/add second address** **Section C – change billing address** **Section D – change mailing address** email the completed form to: Networkmanagement@IowaTotalCare.com
If nothing above applies	Provider Change Form (If anything further is needed, Network Management will be in contact).	Please complete the following section: **Section E – OTHER CHANGES** email the completed form to: Networkmanagement@IowaTotalCare.com

Provider Change Form

Please complete this section for all changes listed below:

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

Section A: CHANGE IN PHYSICAL ADDRESS, PHONE OR FAX

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

Previous Practice Location:	**New Practice Location:**
Facility/Provider Name:	Facility/Provider Name:
Address:	Address:
City, State, and ZIP:	City, State, and ZIP:
County:	County:
Phone Number:	Phone Number:
Fax Number:	Fax Number:
Contact Person:	Contact Person:
Email Address:	Email Address:
☐ Term this Address	

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

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Section B: CHANGE or ADD OF ADDITIONAL LOCATION ADDRESS, PHONE OR FAX

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

Facility/Provider Name:	
Additional Location Address:	
City, State, and ZIP:	
County:	
Phone Number:	Fax Number:
Contact Name:	Email Address:

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

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Section C: CHANGE IN BILLING ADDRESS OR BILLING INFORMATION (W9 Required)

Facility/Provider Name:	
New Billing Address:	
City, State, and ZIP:	
County:	
Phone Number:	Fax Number:
TAX ID:	
Exact name reported to the IRS for this Tax ID:	
Contact Name:	Email Address:
***Does this apply to all GNPIs or list GNPIs it applies to?**	

Section D: CHANGE IN MAILING ADDRESS

Facility/Provider Name:	
New Mailing Address:	
City, State, and ZIP:	
Phone Number:	Fax Number:
Contact Name:	Email Address:

Section E: OTHER CHANGES

Effective Date: _____

Type of change (i.e., terming from Iowa Total Care network, addition of accreditation – please include copy of accreditation certificate, closing a location): _____

_____

_____

Explanation for the change: _____

_____

_____

_____

_____ _____

Signature **Date**