Provider Change Form Instructions

Please reference the table below before completing this form. Please attach all applicable forms required for your change. **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.
The Iowa Department of Health and Human Services= Iowa HHS.

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.	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.	To request an amendment, visit our Contract Request Form page (iowatotalcare.com/providers/become-a-provider/contract-request-form.html). Click *Amendment to Existing Contract* and fill out the information requested. A comment may be added to the comment box to indicate what change you are requesting.
I have a facility name *or* TIN change.		
I wish to add another NPI and service.	New credentialing application is required. Facility/provider's NPI must be enrolled with Iowa HHS prior to adding the service. In your email to Iowa Total Care, please explain the change you wish to make.	Please complete and return all required documents listed in the Facility/Ancillary Provider Application (iowatotalcare.com/contracting-credentialingforms). Submit completed form and attachments: 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 Iowa HHS prior to adding the service. In your email to Iowa Total Care, please explain the change you wish to make.	Please complete and return all required documents listed in the Facility/Ancillary Provider Application (iowatotalcare.com/contracting-credentialingforms). Submit completed form and attachments: NetworkManagement@IowaTotalCare.com.

Change Type	Documents Required	Instructions
Practitioner needs to add, term, or make a 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 Iowa Total Care's Practitioner & Facility Roster (Excel) Forms or the Practitioner Data Form (PDF) (iowatotalcare.com/contracting-credentialingforms) For questions or concerns email: NetworkManagement@IowaTotalCare.com
I have a practitioner with a name change.	Provider Change Form **and** legal documents such as an updated medical license and an updated Drug Enforcement Administration, if available. **Section E – OTHER CHANGES**	Please complete and email Provider Change Form and legal documents to Iowa Total Care: 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. For each service location, must complete a Provider Accessibility Initiative (PAI) Survey (iowatotalcare.com/providers/contracting---credentialing/improving-accessibility.html).	Please complete the Provider Change Form attached to these instructions and complete one of the following: **Section A – change physical address,** **Section B – change/add second address,** **Section C – change billing address, or** **Section D – change mailing address.** Email the completed form to: NetworkManagement@IowaTotalCare.com
If nothing above applies.	Provider Change Form For additional needs, 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:
Phone Number:	

Has provider completed cultural competency training? ☐ Yes ☐ No

If yes, did the training include the following?

African American	☐ Yes ☐ No	Asian	☐ Yes ☐ No	☐Other: _____
Alaskan Native	☐ Yes ☐ No	Hispanic/Latino	☐ Yes ☐ No	If other is selected, name what was included in training.
American Indian	☐ Yes ☐ No	Pacific Islander	☐ Yes ☐ No	

Practitioner Race: (*Optional*)	Practitioner Ethnicity: (*Optional*)
☐ American Indian and Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	☐ Hispanic or Latino ☐ Non-Hispanic or Latino

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:	Email:
☐ Term this Address	

Office hours at this location? ☐ Open 24 hours – or hours of operation below (*please complete*):

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Section B: CHANGE TO or 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:

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:
***Does this apply to all GNPIs or list GNPIs it applies to?** ☐ Yes ☐ No **If no, list all GNPIs to which it applies:**	

Section D: CHANGE IN MAILING ADDRESS

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

Section E: OTHER CHANGE

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**