PROVIDER UPDATE / CHANGE FORM

CHORUS COMMUNITY HEALTH PLANS

This form should be used when changing a Medicaid practitioner or provider name, location, phone or fax number, billing or email address, and office hours. Please email or mail to Chorus Community Health Plans.

- Email to: cchp-providerupdates@chorushealthplans.org
- Mail to: CCHP Provider Relations
  P.O. Box 1997, MS 6280
  Milwaukee, WI 53201-1997

Type of change: _____

Effective date of change:

SECTION 1: OLD INFORMATION (Note: Changes for practitioners and/or providers through a group must be submitted by the group.)

NAME OF ORGANIZATION (INCLUDE LEGAL NAME DOING BUSINESS AS)	FEDERAL TAX ID NUMBER	GROUP NPI 2 INDIVIDUAL NPI	

PHYSICAL ADDRESS

STREET ADDRESS	CITY	STATE	ZIP
PHONE NUMBER	FAX NUMBER		

MAILING ADDRESS

STREET ADDRESS	CITY	STATE	ZIP
PHONE NUMBER	FAX NUMBER		

BILLING ADDRESS

ADDRESS	CITY	STATE	ZIP
PHONE NUMBER	FAX NUMBER		

SECTION 2: NEW INFORMATION (Only complete all the fields of item that has changed.)

NAME OF ORGANIZATION (INCLUDE LEGAL NAME DOING BUSINESS AS)	FEDERAL TAX ID NUMBER (TIN)	GROUP NPI 2 INDIVIDUAL NPI	

PHYSICAL ADDRESS ○ UNCHANGED

STREET ADDRESS	CITY	STATE	ZIP
PHONE NUMBER	FAX NUMBER		

MAILING ADDRESS ○ UNCHANGED (ONLY COMPLETE IF YOU'RE NOT ABLE TO ACCEPT MAIL AT YOUR PHYSICAL ADDRESS)

STREET ADDRESS	CITY	STATE	ZIP
PHONE NUMBER	FAX NUMBER		

BILLING ADDRESS ○ UNCHANGED

ADDRESS	CITY	STATE	ZIP
PHONE NUMBER	FAX NUMBER		

SECTION 3: PERSON COMPLETING FORM

NAME OF ORGANIZATION YOU REPRESENT	TITLE		
STREET ADDRESS	CITY	STATE	ZIP
PHONE NUMBER	EMAIL ADDRESS		

SECTION 4: ROSTER OF PRACTITIONERS / PROVIDERS PRACTICING WITH GROUP (IF NEED MORE ROOM, ATTACH SEPARATE ROSTER SHEET)

FULL NAME	ACCEPTING NEW PATIENTS?	FULL NAME	ACCEPTING NEW PATIENTS?
	☐ YES ☐ NO		☐ YES ☐ NO
FULL NAME	☐ YES ☐ NO	FULL NAME	☐ YES ☐ NO
FULL NAME	☐ YES ☐ NO	FULL NAME	☐ YES ☐ NO

ARE ALL PRACTITIONERS IN GROUP STATE OF WISCONSIN MEDICAID CERTIFIED? ☐ YES ☐ NO

IS ANYONE IN YOUR PRACTICE UNABLE TO BILL WISCONSIN MEDICAID DUE TO BEING INVESTIGATED? ☐ YES ☐ NO

IN ADDITION TO ENGLISH, WHAT LANGUAGES DO YOU SPEAK IN YOUR OFFICE? ☐ SPANISH ☐ HMONG ☐ OTHER: _____

SECTION 5: HOURS OF OPERATION (EXAMPLE: 8 a.m.)

MONDAY OPEN	MONDAY CLOSE	TUESDAY OPEN	TUESDAY CLOSE	WEDNESDAY OPEN	WEDNESDAY CLOSE	THURSDAY OPEN	THURSDAY CLOSE	FRIDAY OPEN	FRIDAY CLOSE	SATURDAY OPEN	SATURDAY CLOSE	SUNDAY OPEN	SUNDAY CLOSE
REGULAR		REGULAR		REGULAR		REGULAR		REGULAR		REGULAR		REGULAR	
URGENT CARE		URGENT CARE		URGENT CARE		URGENT CARE		URGENT CARE		URGENT CARE		URGENT CARE	

SECTION 6: FEDERAL TAX ID NUMBER (TIN) CHANGES

Changes in a tax ID number or name require you to submit a W-9 form or IRS letter (SS4 or 147C). Please attach to this form and email to: cchp-contracting@chw.org. (To email, file size not to exceed 4MB & types accepted: .doc; .docx; .rtf; .xls; .pdf.)

Did you attach supporting documents? ☐ YES ☐ NO

SECTION 7: BEHAVIORAL HEALTH PROVIDER INFORMATION

If you're a Behavioral Health provider, please answer the following questions:

1. **Do you provide home visits?** ☐ YES ☐ NO
2. **Are you able to schedule a patient visit within seven days of discharge from an inpatient facility?** ☐ YES ☐ NO
3. **Do you provide day treatment?** ☐ YES ☐ NO

SECTION 8: EMAIL ADDRESS CHANGE

ORGANIZATION NAME(S) ASSOCIATED WITH THIS EMAIL ADDRESS	
OLD EMAIL ADDRESS	NEW EMAIL ADDRESS

COMMENTS:

INTERPRETER SERVICES

Chorus Community Health Plans (CCHP) complies with all applicable civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, disability, or other legally protected status, in its administration of the plan, including enrollment and benefit determinations.

- On-site interpreter services are provided to CCHP members through Language Source.
- Telephonic interpreter services are provided to CCHP members through Pacific Interpreters.
- For sign language services, call a CCHP Member Advocate at **1-877-900-2247.**

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