CHORUS COMMUNITY HEALTH PLANS

PROVIDER UPDATE / CHANGE FORM

Complete this form when changing/updating a Medicaid practitioner or provider name, location, phone/fax, email, billing address and/or office hours.

Mail to: CCHP Provider Relations
PO Box 1997, MS6280
Milwaukee, WI 53201-1997

or email: cchp-providerupdates@chorushealthpppplans.org

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: