

Oregon and Washington Provider Demographic Update



The information on this form is required for claims processing and directory listings. Please use additional forms for additional practice locations or practitioners/organizations. **Are you credentialed through an independent provider association (IPA) or Accountable Care Organization (ACO)?** If so, please notify them directly. PacificSource is unable to make any changes related to IPA providers without notification from the IPA.

1. What change(s) are you making with this form?

Add existing credentialed provider to group	Provider name change:
Update demographic information	From _____ to _____
Add provider to hospital-based location*	NPI change:
Add new tax ID number: _____	From _____ to _____
Update tax ID: _____	Termination (date): _____
	Reason: _____

Effective date for this change at your organization: _____

Effective date will match the date of credentialing approval, provided a contract is in effect on that date. Additionally, Oregon Medicaid providers (or organizations) must have active Medicaid enrollment.

This provider is: Contracted directly with PacificSource

Contracted through an IPA or ACO? Providers on Delegated Credentialing Agreements must notify the entity that credentials their providers and/or facilities of any changes.

2. Provider information (name as shown on CMS 1500 field 31 or UB box 1)

Individual practitioner	Organization/Group	PCP	Specialist
Name _____			
NPI _____	Degree _____	Birth date: _____	Man <input type="checkbox"/> Woman <input type="checkbox"/> X <input type="checkbox"/>
License No. _____		DEA No. _____	

3. Practice location information (for patient visits and directory listing)

Practice name (as it should appear in directories) _____

Address _____

City _____ State _____ ZIP _____ County _____

Practitioner Specialty (as practicing at this location) _____

Search the NPI directory for specialties at NPIRegistry.cms.hhs.gov.

Are you solely providing services via telemedicine? Yes No

Location NPI _____ Tax ID No. (attach IRS W9) _____

Contact name _____

Contact email _____

Practice phone _____ Practice fax _____

*A hospital-based provider is one who practices exclusively in an inpatient setting. A credentialing application is not required.

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4. Billing information (as billed on CMS 1500 field 31 or UB box 2)

Same as above

Billing name (as it appears on claims) _____

Address _____

City _____ State _____ ZIP _____ County _____

Billing contact name _____

Billing contact email _____

Billing contact phone _____ Billing contact fax _____

5. Other changes to provider directory

6. Summary of changes/notes

Form completed by _____

Email _____ Phone _____

Submit this form to PacificSource by mail, fax, or email.

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Fax: 541-225-3643

Email: ProvNetSup@PacificSource.com