

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

**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](http://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.

*Continued on next page >*

#### 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

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#### 6. Summary of Changes/Notes

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Form completed by \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_

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

Mail: PO Box 7068, Springfield, OR 97477

Fax: 541-225-3643

Email: [provnetsupport@pacificsource.com](mailto:provnetsupport@pacificsource.com)