Ownership and acquisition change request form

Providers and practices going through an acquisition or acquiring another practice are required to report any changes.

All acquisitions must be reported **at least 30 days before the effective date.** If you fail to provide the information requested in this form by the applicable deadline, PacificSource may take action up to and including termination of your contract with PacificSource.

Who needs to complete this form:

- Both entities associated with ownership and acquisition
- Businesses acquiring or merging with a new provider or practice
- Those participating in a buyout
- In- and out-of-network providers

Required documentation:

Please email us the following after you complete your application:

- Provider W-9
- Official documentation of acquisition
- Provider Roster (if you answered "Yes" below)

Note: Failure to provide the required documentation will result in your request being incomplete.

Provider acquisition information

New legal name _____

Prior legal name _____

New tax ID _____ Prior tax ID _____

New NPI _____ Prior NPI _____

New DBA name _____

Prior DBA name _____

New CLIA number _____ Prior CLIA number _____

Seller information

Legal name _____ Tax ID _____

NPI _____ DBA name _____ CLIA number _____

Continued >

Primary practice information

Street address _____ Suite/Floor _____

City _____ State _____ Zip _____ County _____

Phone _____ Fax number _____

Provider Roster

Do you have a Provider Roster? ☐ Yes ☐ No

If you don't, you'll need to give us the name and NPI number of each provider at your practice. If your practice contains more than eight providers, you need to submit the roster as an Excel file.

Practice billing information

Address _____ Suite/Floor _____

City _____ State _____ Zip _____ County _____

Phone _____ Fax number _____

Billing contact

Name _____

Email _____

Phone _____ Fax number _____

Attestation

I understand that noncompliance with any of the above may affect my eligibility to be an in-network provider with PacificSource Health Plans, PacificSource Community Health Plans (Medicare), and PacificSource Community Solutions (Medicaid). I attest that I am in compliance with the requirements above.

Seller signature _____ Date _____

Purchaser signature _____ Date _____

Please return this form to ProviderContracting@PacificSource.com.