Oregon and Washington Provider Demographic Update

PacificSource HEALTH PLANS

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
- ☐ Update demographic information
- ☐ Add provider to hospital-based location*
- ☐ Add new tax ID number: _____
- ☐ Update tax ID: _____
- ☐ Provider name change: From _____ to _____
- ☐ NPI change: From _____ to _____
- ☐ 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 ☐ Woman ☐ X

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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