BROWN & TOLAND PHYSICIANS

PROVIDER CHANGE OF INFORMATION FORM

ALL RQUESTED CHANGE OF INFORMATION FORMS MUST BE COMPLETED, SIGNED AND DATED TO PROCESS. INCOMLETE FORMS WILL CAUSE DELAY. NOTE THAT REQUEST OF INFORMATION CHANGE MAY REQUIRE CONTRCTUAL CHANGES WITH BROWN & TOLAND PRIOR TO SUBMITTING CHANGES TO THE HEALTH PLANS. CHANGES CAN TAKE UP TO 60 DAYS WITH CONTRACTED HEALTH PLANS.

Please check applicable boxes, fill in effective date(s), and complete relevant section(s).

ALL INFORMATION IN THIS SECTION IS REQUIRED

Provider Name (Please print/type):______________________________

Group Name (Please print/type): ______________________________

Does the change apply to all providers in your group? ☐ **Yes** ☐ **No**

Provider NPI ____________ **Allscripts Physician?** ☐ **Yes** ☐ **No** **Shareholder?** ☐ **Yes** ☐ **No**

New Agreement:

Request for new agreement(s) is subject to approval.

PPO: ☐ **Yes** ☐ **No** **Medi-Cal:** ☐ **Yes** ☐ **No**

Practice Status:

Closing Practice: Must complete this form 90 days in advance of the "closed practice" effective date. (Internal BTP approval is required).

Leave of Absence: Must attach a letter which states the reason for the LOA, the time period (start and end dates), and the name of the covering physician. Leave cannot exceed 6 months)

☐ Open ☐ Closed ☐ Leave of Absence ☐Effective Date:____________

Practice Address:

☐ Add ☐Change ☐Remove ☐Effective Date: ____________

Original Information:

Practice Name: ______________________ Tax ID: ____________

Address: ______________________________

Phone No.: ____________________ Fax No.: ____________________

Office Mgr.'s Name: ____________________ Office Mgr.'s Email: ____________________

Physician's Email: ____________________ Website: ____________________

Office Hours: ____________________ Office Language(s) ____________________

Revised Information:

Practice Name: ______________________ Tax ID: ____________

Address: ______________________________

Phone No.: ____________________ Fax No.: ____________________

Office Mgr.'s Name: ______________________________ Office Mgr.'s Email: ______________________________

Physician's Email: ______________________________ Website: ______________________________

Office Hours: ______________________________ Office Language(s) ______________________________

Does this apply to your notice address? ☐ **Yes** ☐ **No**

Tax ID / Billing Address: ***(Must include W9.*** *Only one billing / payment address per Tax ID)*

☐ Add ☐ Change ☐ Terminate ☐ Effective Date: ____________________

Original Information:

Master Vendor Name: ______________________________ Tax ID: ____________________

Address: ____

Billing Phone: ______________________________ Billing Fax: ______________________________

Revised Information:

Master Vendor Name: ______________________________ Tax ID: ____________________

Address: ____

Billing Phone: ______________________________ Billing Fax: ______________________________

Group NPI (Type 2):

☐ Add ☐ Change ☐ Terminate ☐ Effective Date: ____________________

Original Information:

Master Vendor Name: ______________________________ Tax ID: ____________________

NPI Type 2: ______________________________

Address: ____

Billing Phone: ______________________________ Billing Fax: ______________________________

Revised Information:

Master Vendor Name: ______________________________ Tax ID: ____________________

NPI Type 2: ______________________________

Address: ____

Billing Phone: ______________________________ Billing Fax: ______________________________

Hospital Affiliations:

Original Information:

Hospital Name: ______________________________ Do you have admitting privileges? ☐ **Yes** ☐ **No**

Hospital Privilege Type (Active, Provisional, etc) ____________________

Revised Information:

Hospital Name: ______________________________ Do you have admitting privileges? ☐ **Yes** ☐ **No**

Hospital Privilige (Active, Provisional, etc) ____________________ Effective Date: ____________________

Changes to Agreements:
Request for changes to agreement(s) is subject to approval.

PPO Contracted Threshold Change: ☐ **Yes** ☐ **No**

Termination Requested

☐ PCP ☐ Specialist

☐ Termination, from Brown & Toland Physicians Effective Date of Termination: ____________________

☐ Termination, PPO Only Effective Date of Termination: ____________________

☐ Termination, Medi-Cal Only Effective Date of Termination: ____________________

☐ I supervise the following NP(s)PA(s): ____
Print Name of NP(s)PA(s)

FOR PCPs, I reassign my members to: ____
Print Name of Reassigning Physician

How can patients access their charts? ____

Reason for leaving Brown & Toland Physicians: ____________________________________

____

Other Change:

☐ Add ☐ Change ☐Effective Date: ____________________

Original Information:

____

Revised or Additional Information:

____

I hereby instruct Brown & Toland Physicians to correct/update the above information in my provider record. I understand that no changes will be made unless this form is completed and SIGNED. I also understand that any claims sent with updated information that is not yet corrected on my record may be processed incorrectly or denied. Further, I understand that any of the above changes that require a modification to my contract will need to be approved and executed by the contracting department.

______________________________________ ______________________________

Authorized Signature Date

Please email this form to: **Credentialing_Dept@btmg.com**. This is the preferred method and will ensure the most expedient processing. If you prefer to mail your documents, please send to:

Brown & Toland Physicians
ATTN: Credentialing Department
P.O. Box 72710
Oakland, CA 94612

Or fax this form to**: (415) 972-4389**

If you have any additional questions, please email the Credentialing Department at **Credentialing_Dept@btmg.com** or call **(415) 972-4380**.

Revised 09/05/2019