Formerly Known As Monroe Plan for Medical Care

PRACTITIONER DEMOGRAPHIC CHANGES

Elm & Oak Health must be notified immediately of any change to provider information/status. Complete and return with the W-9 by email, phone or fax to the information below. All information must match NPPES.

Today's Date:	**Effective Date:**	**Provider Name:**
DEA Certificate#	**Provider License#/State:**	**Individual NPI#**
CAQH# **MEDICAID#**	**Accepting new patients?** ☐YES ☐NO **PCP?** ☐YES ☐NO **Panel?** ☐OPEN☐CLOSE	**Language(s) other than English:**

TYPE OF CHANGE: Circle the appropriate fields. *Mid-Level Supervising MD

ADD	**UPDATE**	**CORRECT**	**CLOSE**	**TERMINATE- allow 30 days prior to termination**
Termination reason:				

CHANGE TO: Circle the appropriate fields.

Name/Provider	**Telephone/Fax**	**Email**	**NPI**	**Taxonomy**	**Tax ID***
Address:	**Primary Office**	**Additional Office**	**Correspondence**	**Remittance**	**Medical Record**

NPI Number:

Group- Entity NPI (Type 2)	**Group Name:**
Group- Entity NPI (Type 2)	**Group Name:**

Taxonomy Code (required):

Primary Specialty:	**Taxonomy Code:**
Second Specialty:	**Taxonomy Code:**
Third Specialty:	**Taxonomy Code:**

Current Tax ID#: _____ ▢ **Keep current Tax ID** ▢ **Terminate from Current Tax ID**	**Reason for New Tax ID:*- A copy of the W-9 form must be attached.** _____ ▢ **Joining an existing TIN/Practice** ▢ **Change in ownership** ▢ **New Name for existing Tax ID** ▢ **Other:**_____

Mail or Email this form to:
Elm & Oak Health
1120 Pittsford Victor Road,Pittsford, NY 14534
Fax: 716-748-6987
PFMemails@elmandoakhealth.com

Please note: **A correspondence street level address must be applied when a remittance address is a PO Box. Please use additional sheets when needed for multiple addresses.**

Address A ○ Old Address ○ New Address	**Street:**_____ **STE:**_____ **City:**_____ **State:**_____ **ZIP Code:**_____	○ Primary Office ○ Additional Office ○ Correspondence ○ Remittance ○ Medical Record
Phone:_____ **Fax:**_____	**Office Hours:**	**Handicap accessible:** **Public Transportation:**
Address B ○ Old Address ○ New Address	**Street:**_____ **STE:**_____ **City:**_____ **State:**_____ **ZIP Code:**_____	○ Primary Office ○ Additional Office ○ Correspondence ○ Remittance ○ Medical Record
Phone:_____ **Fax:**_____	**Office Hours:**	**Handicap accessible:** **Public Transportation:**
Address C ○ Old Address ○ New Address	**Street:**_____ **STE:**_____ **City:**_____ **State:**_____ **ZIP Code:**_____	○ Primary Office ○ Additional Office ○ Correspondence ○ Remittance ○ Medical Record
Phone:_____ **Fax:**_____	**Office Hours:**	**Handicap accessible:** **Public Transportation**
Address D ○ Old Address ○ New Address	**Street:**_____ **STE:**_____ **City:**_____ **State:**_____ **ZIP Code:**_____	○ Primary Office ○ Additional Office ○ Correspondence ○ Remittance ○ Medical Record
Phone:_____ **Fax:**_____	**Office Hours:**	**Handicap accessible:** **Public Transportation:**

All members can make an appointment and be treated at ***Address***: ***A*** ☐ ***B*** ☐ ***C*** ☐ ***D*** ☐	Hospitalist at ***Address***: ***A*** ☐ ***B*** ☐ ***C*** ☐ ***D*** ☐

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OFFICE CONTACT INFORMATION

Please use this space for indicating the best points of contact for each category. All email communications will also be sent to the email listed under "General Molina Updates"

Best contact (Please list name or N/A)	Email	Phone Number
General Molina Updates		
Credentialing-		
Office Manager-		
Quality-		
Clinical-		
Pharmacy-		
Billing-		

Authorized person completing form:

Name:	Phone:	Email:

Mail or Email this form to:
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