

**HEALTHPLUS OF MICHIGAN  
PROVIDER RECORDS CHANGE FORM**

The purpose of this form is to document business record changes requested by HPM participating providers. In order to ensure accuracy of the provider record database for claims reimbursement, mailings, etc., HPM requires requested record changes be submitted in writing via the form below. The form will serve as documentation for said change requests. Completion of the form will serve as an audit source for HPM to verify all key record elements related to a providers participating status with HPM.

**In order for the request to be approved, the necessary change information needs to be complete. Other than required information, only the information that needs to be changed will need to go on this form. The requested change will not be entered into the HPM provider record database until all changed information fields on the form are completed and supporting documentation is received. Please fax completed form to: 810-230-2081.**

\*Requestor Name: \_\_\_\_\_ \*Phone #: \_\_\_\_\_ \*Fax #: \_\_\_\_\_

**Provider Completion Section**  INDEPENDENT  EMPLOYED/FACILITY ASSOCIATED CONTRACTED

	Current Information that is in HealthPlus' System	New Information Provider Wants in HealthPlus' System
*Provider Name: Include Degree (MD/DO)		
*Provider ID #:		
Group Name:		
Group Provider ID #:		
Specialty:		
Hospital Name:		
PHO Affiliation Name:		
Physical Office Location(s) for this provider #:		
Physical Office Telephone #:		
Physical Office Fax #:		
Pay to Name:		
Pay to address for this provider #:		
Billing Telephone #:		
Billing Fax #:		
*Tax ID #:		
Is billing address same as W-9 address? If not indicate W-9 address: (W9 or Form 8109 attached)		
DEA#:		
Medicare #:		
Medicaid #:		
License #:		
NPI#:		
Accept status change:		
*Effective Date of This Change:		

Notes:

Additional Location  New Location  Term Old Location

Line of Business:	All:	Commercial/Options:	PPO:	HP/SM:	M+C:	SHP:	BHP:	GHP:
PPG#:	From:	To:						
Risk Withhold %:	From:	To:						
AMISYS:								
PPG System								

\*Required Field

## HEALTHPLUS PROVIDER CHANGE FORM DIRECTIONS

**Please print all information on the change form**

FORM FIELD NAME	DIRECTIONS
<b>Provider Name and Degree (MD/DO)</b>	Enter the first name, middle initial, and last name of the provider the change for. Example: Jane R. Smith, M.D.
<b>Provider ID #</b>	HealthPlus assigns a provider ID # to each provider. Place your HealthPlus provider ID # here. If you do not know the provider ID #, please contact Customer Service @ 800-332-9161 (Flint) or 800-942-8816 (Saginaw)
<b>Group Name:</b>	If the provider is part of a group and the group bills HPM using the tax ID # used to complete this form, indicate the group name here. Please indicate the full group name, such as ABC Radiology, Inc.
<b>Group Provider ID #</b>	If you do not know the provider ID #, please contact Customer Service @ 800-332-9161 (Flint) or 800-942-8816 (Saginaw)
<b>Specialty</b>	Indicate the provider's speciality here. Example, cardiology.
<b>Hospital Name</b>	List the hospital(s) name(s) that the provider is affiliated with here. Provider can be affiliated with more than one hospital.
<b>PHO Affiliation Name</b>	List the provider's PHO(s) affiliation(s) name here. Example: Genesys PHO. Provider can be affiliated with more than one PHO.
<b>Physical office Location(s) for this provider #</b>	List each physical location associated with the provider # or group # here. Include building #, street name, suite #, city, state and zip code. This cannot be a P.O. Box as these are the locations listed in the provider directory.
<b>Physical Location(s) Phone #(s)</b>	List each physical location's 10 digit telephone # here. This is the telephone # that will be listed in the directory. Example 989-123-4567
<b>Physical Location(s) Fax #(s)</b>	List the 10 digit fax # for each physical location: Example: 989-123-4567
<b>Billing Location(s)</b>	List the billing address for the tax ID indicated on this form. Include building #, street name, suite #, city, state and zip code.
<b>Billing Location(s) Phone #</b>	List the telephone # that the HPM billing department would call with questions.
<b>Billing Location(s) Fax #</b>	
<b>Tax ID #</b>	List the tax ID # here. If the tax ID # is changing for the provider or group, a W9 <b>must</b> accompany this change request.
<b>W9 Address</b>	Is billing address same as W-9 address? If not, please indicate address:
<b>DEA#</b>	List the provider's DEA # here
<b>Medicare #</b>	List the provider's Medicare ID # here
<b>Medicaid #</b>	List the provider's Medicaid ID # here
<b>License #:</b>	List the provider's State of Michigan License # here
<b>Accept status change</b>	
<b>Effective Date of this Change</b>	Indicate the six digit date the change is effective. Example: 060102
<b>If your on-call status is changing, please complete the HealthPlus of Michigan on-call form.</b>	